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EDITOR . . . . . GEORGE H. KRESS

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Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

EDITORIALS†

NEW CALIFORNIA LAWS: OF PUBLIC HEALTH AND MEDICAL INTEREST

Legislative Sessions Are Synonymous with New Laws.—Law-making activities of a session of the California Legislature are biennially reflected in the pages of the OFFICIAL JOURNAL of the California Medical Association, through informative comment on several hundred proposed laws relating to public health and medical practice. The number of such proposed statutes, instead of growing less, seems ever to be on the increase.

Much of the legislation here spoken of may be said to be decidedly inimical, rather than favorable, to public health and medical practice standards; yet even though having little real merit, the acts submitted, once they have been introduced at Sacramento, demand careful and constant attention lest, by hook or crook, they slip out from committee files, to secure places on the Assembly or Senate calendars. Even though a certain type of legislation is almost sure to be defeated in the upper or lower chambers, the discussion likely to take place concerning such measures may make good—because sensational—press stories. In this way, at times, through unfortunate publicity, much harm can be done to public health and medical practice interests.

* * *

Summary of Public Health and Medical Practice Legislation in This Issue.—In the five to six months during which the Legislature is in session, only a few of the more pressing legislative proposals are singled out for special comment in CALIFORNIA AND WESTERN MEDICINE. Once, however, the Legislature has adjourned, and the last day for gubernatorial sanction or veto is a thing of the past, it is in order, and urgently proper that a brief survey be given in the OFFICIAL JOURNAL of the more important measures that may have demanded attention and action by the Committee on Public Policy and Legislation, the officers, the component county societies and their members.

Therefore, in the current issue of CALIFORNIA AND WESTERN MEDICINE a summary is printed, both for the purpose of record, and in the hope that readers will at least scan it. (See page 186.)

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

A glance at the number and nature of the many proposed laws there enumerated should convince even those who are skeptical that the constituted authorities of the Association have abundant work cut out for them, once a California Legislature convenes for its biennial law-making. If space permitted, many an interesting story could be related concerning some of the measures—on what took place, for example, in committee meetings, behind the scenes, and on the Assembly and Senate floors.

* * *

Comments on New Statutes with Penalizing Clauses.—Because several of the laws that will become operative about September 19 have important implications in medical practice, some additional comment will now briefly be made:

Prenatal and Premarital Laws.

Chapter 127, California Acts of 1939, on Prenatal Examination, and Chapter 382, on Premarital Examination, are two laws, the complete text of which appeared on page 71 of CALIFORNIA AND WESTERN MEDICINE for July, 1939, with some editorial comment on page 6 of that number. Attention is especially called to the misdemeanor provisions for noncompliance with the law's provisions.

On page 139 of the August issue will also be found a question-and-answer résumé of the Premarital Law (Chapter 382); and it is suggested that all licensed physicians acquaint themselves with the interpretative comment concerning that new statute which goes into effect on September 19, 1939. From now on patients who contemplate matrimony will be consulting their physicians on these matters, and it may be embarrassing not to have the correct answers at hand. (In this issue, see items on pages 200-202 and 208-211.)

Compensation Protection for All Employees Law.

Assembly Bill 1521 lays down stringent provisions whereby employers must carry compensation insurance for all employees (casual employees and domestics working less than fifty-two hours weekly excluded), be they only one. Physicians, therefore, must carry compensation insurance coverage for all office employees and nurses. Violation of the new statute constitutes a misdemeanor. The text of the measure appears in this issue of CALIFORNIA AND WESTERN MEDICINE, on advertising page 45.

Epilepsy Law

A new law, operative on September 3, makes epilepsy a reportable disease. A brief item concerning this statute appears in this issue, on page 183.

Narcotic Prescription Laws.

In the April issue of CALIFORNIA AND WESTERN MEDICINE, on page 313, appeared a letter worthy of perusal, from Paul E. Madden, Chief, California Division of Narcotic Enforcement, in which was outlined certain proposed legislation on the giving of prescriptions for narcotics. The statutes then suggested having been enacted, and receiving the approval of the Governor, were expected to become operative in September, when a violation of the new law will be regarded as a misdemeanor. Hence, every physician owes it to himself to become acquainted with its stipulations. The informative letter referred to above is worthy of perusal.

(Since writing the above, Chief Madden tells us that the State's emergency fund has been greatly depleted because of forest-fire expense, and that, on that account, it is probable that the new law will not be carried out on September 19. He also states that, prior to the law's enforcement, the books to be used by physicians must first be distributed. Therefore, until such time as the California Division of Narcotic Enforcement supplies the new narcotic booklets, the procedures at present in vogue may be carried on.)

1940 ANNUAL SESSION: HOTEL DEL CORONADO

Next Annual Session: Attention of Essayists and Exhibitors Requested.—At the top of the front cover of each issue of the OFFICIAL JOURNAL appear the following notices:

NEXT ANNUAL SESSIONS

California Medical Association, Hotel Del Coronado, Coronado, May 6–9, 1940.

American Medical Association, New York, June 10–14, 1940.

Attention, therefore, is directed anew to these announcements, not only to remind component county societies and their members of the dates of the next annual session of the State Association, but to especially request all who have papers or scientific exhibits in mind to promptly communicate with the officers of the scientific sections, before which the papers should preferably be given. The list of section officers appears in every issue of the OFFICIAL JOURNAL, on advertising page 6. Letters should be sent to the proper section secretaries.

Communications relative to scientific exhibits should be sent to the Association Secretary at the California Medical Association central office in San Francisco.

Requests for hotel reservations should go forward to the Hotel Del Coronado, Coronado, California, in care of the assistant manager, Mr. Ernest R. Tiedemann.

SPECIAL ASSESSMENT OF THE HOUSE OF DELEGATES

House of Delegates Resolution No. 6.—At the Del Monte annual session, the House of Delegates deemed it wise to approve Substitute Resolution No. 6, which provided for a special assessment of $10, payable by all active members, as of date of June 1, 1939. Concerning the provisions contained in the resolution, informative communications have been sent by the California Medical Association Council to all component county societies and to every member of the California Medical Association. In the current issue, also, appear the minutes of the Council's meeting held on August 5, 1939, and to these the attention is called of all members who may have special interest in the plans that were comprehended in

the various Del Monte resolutions leading to the drafting of Substitute Resolution No. 6, and who would desire an opportunity to read the report of the Committee on Public Health Education dealing with its proposed activities. (For minutes, see page 178.)

* * *

Medical Profession Has Been Laggard in Publicity Work: The Remedy.—It is generally agreed that one of the reasons why the medical profession today is the target for so many antagonistic onslaughts, is the fact that in recent years medical men and women have become so engrossed in scientific advancements in preventive and curative medicine that they have failed to take into proper consideration and evaluation the seething unrest in the social welfare phases of modern-day living. Be that as it may, here again we deal not with hypotheses, but are confronted with face-to-face problems that must be solved. Everywhere, in the press and over the air, on the lecture platform, and before clubs and gatherings of all kinds, health issues continue to be matters of discussion and propaganda, and of so pressing a nature that they will not be put aside. To believe, therefore, that such mental unrest, regarding these topics—matters now of practically popular discussion—will shortly waft itself away, and that all will soon be well, is probably nothing else than wishful thinking. It can no longer be doubted that a multitude of citizens are beginning to be skeptical concerning the altruism of physicians, thereby becoming increasingly the victims of specious thinking and propaganda, so constantly set before them in most alluring fashion.

By contrast, the medical profession has nothing to conceal. It is proud of its record of generous service to humanity. It asks for little praise, but it is pained, nevertheless, at unjust accusations and aspersions. Even though its disciples know they are largely in the right, under present conditions, that does not suffice. It must be made clear to laymen that many statements aimed at public health and medical practice methods are in error. That is why work such as is contemplated in Substitute Resolution No. 6 of the Del Monte House of Delegates, and as outlined in the report of the Special Committee on Public Health Education which the Del Monte resolution brought into being, is of the highest importance to the people of California. Members of the Association are urged to read the report, on page 179 of this issue, as given under items 11 and 16 of the August 5 Council minutes. Members of the Association are also requested to feel free to send to the Committee on Public Health Education* any suggestions concerning publicity work.

CHIROPRACTIC INITIATIVE TO BE ON NOVEMBER 7, 1939, BALLOT AS PROPOSITION NO. 2

The Way of Medical Cults.—Cultist medicine rarely rests, and it is not necessary here to discuss why this is so. Let it suffice to state that where there is much to gain and so little to lose there always will be found those who are willing to seek the more. That may explain in part, also, why contributions of twenty-five, fifty, or one hundred dollars are more easily obtained from the disciples of cultist healing-art practice than from licentiates of scientific and nonsectarian medicine. Many members of the latter group cannot understand why the State should expect them—from whom exacting educational and training qualifications have been demanded—to spend their dollars to protect the public from healing-art practitioners who have had insufficient training for certain work they aspire to do. These are contemplative considerations, however, of little moment when one is confronted, not with theory, but positive fact.

* * *

Proposition No. 2 (Chiropractic Initiative) Will Be on the November 7, 1939, Ballot.—In the matter now referred to, such a fact is met with in the Chiropractic Initiative, which has been given the number, Proposition No. 2, and which, by ruling of the Attorney-General, will have a place on the "Ham and Eggs" ballot of November 7, 1939.

* * *

Cultist Medicine Seeks Always to Extend Its Scope of Practice.—It is an interesting phenomenon to note that once a cultist group secures legal recognition from a commonwealth, its disciples and leaders, as they move forward in material prosperity, seek to broaden the scope of their practice, and to use methods and armamentariums quite different from those permitted in initial statutes pertaining to them. Thus, they usually endeavor to add to the scope of their work, the treatment of diseases and injuries, the care of which was forbidden in the laws granting them their first recognition. What has taken place in California in this respect has also come to pass in other States, likewise unfortunate enough to have multiple licensing boards.

So now, in November of the present year, the citizenry of California will be called upon to decide concerning an extension of chiropractic practice. The limitations of the existing chiropractic statute—passed by initiative vote of the California electorate in 1922—are covered in court opinions handed down by Judge John J. Van Nostrand in the Superior Court of the State of California, in and for the County of San Francisco, and printed in CALIFORNIA AND WESTERN MEDICINE, on page 419 of the issue of November, 1936, and on page 457 of the December, 1938, number.*

* * *

Text of the Chiropractic Initiative.—In the current issue, on page 211, will be found the pending Chiropractic Initiative, to appear on the November 7 ballot. For this reason, it is suggested that members of the California Medical Association take the time to read this proposed law, and then ask of themselves their own interpretations of its implications and possible results to healing-art practice in California in the future. A perusal of the court opinions, above referred to, will shed additional light; because those legal rulings proba-

* The membership of the committee is listed in each issue of CALIFORNIA AND WESTERN MEDICINE, in the roster on advertising page 6.

* See also an item in this issue, on page 213.

bly explain, in part, why so many thousands of dollars were raised to secure the necessary signatures for the November initiative, and to provide funds to carry on an educational campaign necessary for its passage.†

SUPPORT YOUR ADVERTISERS

We Help Ourselves by Helping Others.—For years, on advertising page 8 of CALIFORNIA AND WESTERN MEDICINE, an "Alphabetical List of Advertisers" has been given; and there has also appeared the following footnote to the tabular list, asking readers to remember such advertising patrons:

COÖPERATE WITH YOUR ADVERTISERS

CALIFORNIA AND WESTERN MEDICINE, the official publication of your Association, is made possible in part by reason of the coöperation of business firms and institutions who use advertising space. Their purpose is to direct attention to their products and services to present and future patrons.

Members and readers are urged to give preference to and to patronize these advertisers. When ordering goods, mention CALIFORNIA AND WESTERN MEDICINE.

This coöperation will please the advertiser, add to advertising income, and enable your Association to increase the value of this JOURNAL to members and readers.

The truths embodied in the above text should appeal to every member of the California Medical Association. If the solicited coöperation were given generously, the reputation of the OFFICIAL JOURNAL of the California Medical Association, as a worthwhile advertising medium, would so rapidly spread among manufacturers and others who cater to the needs of the medical profession that the income from advertisements alone would greatly increase, thus making possible a lesser subscription allocation from the annual dues than has been in vogue in recent years.

* * *

United States Postal Laws Make Subscription Rate Necessary: "California and Western Medicine" Rate.—In order to secure second-class postal rate, the United States Post Office Department demands that definite subscription rates be established for members who receive the official journals of their respective organizations. In accordance with the postal laws, the California Medical Association Council, for several years past, established the yearly subscription rate of CALIFORNIA AND WESTERN MEDICINE for Association members at three dollars, or twenty-five cents per copy. When the subscription allocation for California Medical Association members is added to the advertising income of the OFFICIAL JOURNAL, the books show a net balance in the black to the credit of CALIFORNIA AND WESTERN MEDICINE. The subscription price to nonmembers (excepting members of the Nevada State Medical Association, who also receive the JOURNAL at the three-dollar rate) is five dollars per year.

* * *

Coöperation with "California and Western Medicine" Advertisers Requested.—It would not be a difficult task to increase the amount of advertising in CALIFORNIA AND WESTERN MEDICINE if the standards demanded of advertisers were lowered so that proprietary and other announcements could be accepted. That, however, is something that is repugnant to the policy adopted by the California Medical Association, established when it brought the OFFICIAL JOURNAL into existence in November, 1902, to take the place of the *Annual Transactions*—a policy to which the Association has striven to be loyal during the last thirty-six years. In this connection, in the first editorial that graced Volume 1, Number 1, of the OFFICIAL JOURNAL, the founder-editor, Philip Mills Jones wrote:

The CALIFORNIA STATE JOURNAL OF MEDICINE* will hereafter take the place of the Annual Volume of Transactions of the Medical Society of the State of California. . . . In addition to the official reports of the annual meetings of the State Society, and the papers and discussions of the Scientific Section, the JOURNAL will publish a limited number of original articles, reports of county societies, and such other matter as may be of interest.

The advertising pages of the JOURNAL will be limited in number, and will be open only to advertising matter which complies with the strictly ethical standard that is so well understood by all, yet so frequently forgotten—when there is a financial reason to forget!

* * *

Members Are Urged to Read the Advertisements in the "Official Journal."—While more could easily be written on the topic, "Support Your Advertisers," we shall rest at this point, in the hope that members of the State Association will take to heart what has been said and follow up good intentions by regularly scanning the advertising pages of CALIFORNIA AND WESTERN MEDICINE, and writing for literature and information on any and all items in which they may have interest. They may be assured that advertisers, who help make it possible to bring to each member one of the largest of the state medical journals, will appreciate their coöperation. By giving this aid, members will be helping their advertisers, their Association, and themselves. Lend a hand!

WAGNER BILL, S. 1620: AN ILLUMINATING DIGEST OF THE REPORT OF THE SENATE COMMITTEE

On August 4, 1939, the Committee on Education and Labor of the United States Senate, which had been holding hearings on the merits and demerits of Senator Robert F. Wagner's health program bill (S. 1620), submitted a report (No. 1139) to the Seventy-Sixth Congress. Much of the testimony offered at the hearings appeared in succeeding issues of the *Journal of the American Medical Association.*

Physicians who have kept in touch with these proceedings will be interested in the analyses made and conclusions drawn by the Senate Committee on Education and Labor, as submitted by Senator Murray. The forty-two-page report is too lengthy for publication in CALIFORNIA AND WESTERN MEDICINE, but we have pleasure in reprinting, on

† As these comments go forward to the printer, two extremely significant items appeared in the daily press. They are reprinted in this issue on page 197.

* This was the original name of CALIFORNIA AND WESTERN MEDICINE, the California Medical Association at that time being known as the Medical Society of the State of California.

page 214, an excellent digest gleaned from the *Journal of the American Medical Association.*

This should be read by all members of the medical profession, because it indicates the nature of federal legislation that will, of a certainty, be proposed when the second session of the Seventy-Sixth Congress convenes in January, 1940. If some of the proposed legislation is then enacted, it may make for radical changes in medical practice. Take the time, therefore, to browse through the digest. Its perusal will be thought-stimulating.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 178.

EDITORIAL COMMENT†

SPONDYLOLISTHESIS

Spondylolisthesis, or slipping of a vertebra, was first described as a clinical entity eighty-five years ago. Since that time there have been perhaps three eras during each of which a different attitude has been taken toward the fundamental nature of this condition.

The first descriptions of spondylolisthesis were of advanced cases which had been recognized in women in whom an obstruction to labor led, upon examination, to the discovery of a marked deformity of the lower spine. Physical signs were promulgated to facilitate the diagnosis of this condition before labor, and during the latter part of this epoch anteroposterior roentgenograms of the lower spine and pelvis were used to confirm this clinical diagnosis. Much attention was devoted to describing the abnormality and to clinical signs useful for the diagnosis thereof, but little was surmised or known regarding the exact origin of the displacements.

The second era was marked by two changes. The first was the development of satisfactory lateral roentgenologic projections of the lumbosacral region; the second, the advent of the automobile and an apparent increase in the incidence of the lesion. By lateral roentgen examination it became possible to determine not only that forward slipping (usually of the fifth lumbar body) had taken place, but also to measure its degree.

Accidental injuries to the lower back became more frequent because of the automobile, and also because of the increase in industrial employment following the turn of the century. Many of these accident cases were submitted to x-ray examinations and some showed various degrees of spondylolisthesis. It was only natural to assume that the injuries sustained resulted in the changes noted, and it came to be generally believed that spondylolisthesis was the result of trauma to the spine.

The third and current era consists of a period of approximately twenty years, during which considerable anatomical and clinical research upon the spine, and especially the lumbosacral region, has taken place. Anatomical studies have consisted of reviews of large series of spines and x-ray studies, especially of preëmployment groups. Refinements in roentgenologic technique, such as the oblique projections of the lumbar spine, now frequently used, have aided in obtaining a truer insight into the structure and mechanics of the lower spine. These studies have led to the following conceptions regarding spondylolistheses:

1. The neural arch of the involved vertebra is usually defective as a result of anomalies occurring during development. The most common anomaly is a separation, usually bilateral, of the neural arch at the isthmus or interarticular portion; this occurs in the last lumbar segment in more than 80 per cent of cases. Furthermore, as studies of infants and young individuals have been made, it has been demonstrated that spondylolisthesis is not an unusual occurrence in these groups.

2. As a result of acute trauma or, more commonly, repeated minor injuries or long-continued strain (such as the weight of the body, occupational strains, and so forth), the musculofascial and ligamentous structures maintaining the integrity of the involved vertebra stretch or give way, allowing that portion of the vertebra anterior to the bony defect to slip forward or, more correctly, to be forced downward and forward.

3. In approximately one-third of the cases where the fifth or last lumbar body slides downward on the superior sacral surface, it also rotates on the anterosuperior edge of the first sacral segment. If this occurs, the posterosuperior margin of the last lumbar body lies anterior to the postero-inferior margin of the body above it. In no instance, however, is this to be considered a posterior displacement of the fourth on the fifth body, or a "reverse spondylolisthesis."

Since low-back pain is said to be the second most frequent complaint in the field of industrial medicine, and is a frequent concomitant of allegedly compensable injuries, and since many such cases are still being awarded large sums when a spondylolisthesis is shown to be present following the injury, it behooves us to be most cautious in affirming that the bony changes present are the result of a recent trauma. Competent roentgenologic interpretation is of fundamental importance in evaluating the lesions found in these cases, and a thorough roentgen examination must be made if errors are to be prevented. Adequate examinations can rarely be made with small office or portable units. In some instances a positive statement concerning the connection of the displacement with the recent injury must be deferred until a comparison can be made with subsequent roentgen examination, usually after an interval of from four to six weeks.

450 Sutter Street.

HAROLD ARTHUR HILL,
San Francisco.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

ACQUIRED HETEROSPECIFICITY WITH BACTERIA

That chemical implantation of tissue specificities takes place in pathogenic bacteria, the ingrafted or induced colloidal factor being hereditarily transmissible in the microbic cells, is a futuristic deduction currently suggested by Holtman[1] of the Ohio State University. If confirmed, this alleged hybridization between bacteria and environmental colloids will have numerous practical applications in diagnosis and therapeutics.

Clinical interest in possible tissue transformations of bacterial specificity was stimulated by Buchbinder,[2] who first suggested the view that the heterospecificity, or "Forssman antigen," demonstrable in certain intestinal bacteria, is not an essential character of these bacteria. The Forssman antigen is conceivably an implanted colloid, acquired as a result of previous contact with Forssman-positive animal tissues. That such ingrafting of an environmental specificity is a biological possibility, had been previously shown by Veblen[3] of Stanford University. The Stanford bacteriologist grew *B. typhosus, S. viridans* and other microorganisms for several generations in 10 per cent horse-serum, and found that microörganisms so grown acquired horse-protein specificity. The ingrafted specificity could not be removed by repeated washings in Ringer's solution, and was retained for at least twelve subcultures in routine culture media. In her hands the twelfth generation subculture was agglutinated by a 1:1000 dilution of antihorse rabbit precipitin, control cultures being nonagglutinated.

In order to test the possibility that the Forssman antigen is an implanted environmental character in certain gastro-intestinal bacteria, Holtman grew Forssman-negative *E. typhosa* and *B. paratyphosus A* on agar containing Forssman-positive material (*e. g.*, horse-serum), with control growths on routine Forssman-negative medium. He also enclosed Forssman-negative bacteria in collodion sacs, which were inserted into the peritoneal cavities of Forssman-positive guinea pigs. After twenty-one days' exposure to such Forssman-positive environments, the bacteria were repeatedly washed in Ringer's solution and planted on routine Forssman-free media. Holtman found that the resulting subcultures were not only Forssman-positive, but continued to form Forssman specificity for at least fifty test-tube subcultures on routine Forssman-negative media. Heat-killed bacteria similarly exposed to a Forssman environment did not acquire Forssman colloids, irremovable by washing.

Following Veblen's lead, Holtman interprets his results as suggestive evidence that Forssman antigen is incorporated in the cytoplasm of the exposed bacteria, and afterward multiplied in symbiosis with these cells. The conventional assumption of an enzymic activation of latent characters in the exposed bacteria was also considered. As a practical application of such chemical implantation, Holtman showed that two widely different bacterial species, grown in the same Forsman-positive media, might each acquire the environmental character in sufficient titer to render the two species indistinguishable from each other by routine serological tests. Whether or not a reversal of the Buchbinder phenomenon, a destruction or removal of a heterophile character in pathogenic bacteria, is a possibility has not yet been investigated. Such removal of a fractional human specificity from pneumococci, for example, might conceivably render the corresponding antiserum nontoxic for human tissues.

P. O. Box 51. W. H. MANWARING,
Stanford University.

1 Holtman, D. Frank: J. Immunol., 36:405, 413 (May), 1939.

2 Buchbinder, L.: Arch. Path. 19:841, 1935.

3 Veblen, Becky B.: Proc. Soc. Exp. Biol. and Med., 27:204, 1929.

PERIPHERAL VASCULAR DISEASES

Major vessel occlusion may be present in spite of a warm extremity. Subjective and objective sensations of warmth in an extremity are determined primarily by the amount and rate of blood flow in the superficial vessels. The surface of the extremity may feel warm to the touch, due to an adequate blood supply through the superficial vessels. The deeper tissues and muscles, however, may be suffering from a definite circulatory deficiency, giving rise to the symptoms of intermittent claudication, and even rest pain.

* * *

Calcification of the arteries, as revealed by the x-ray or palpating finger, is no true indication of the patency of the lumen of the vessel. It indicates one thing only: the presence of arteriosclerosis with calcification of the vessel wall. Calcification is a problem only when there is marked encroachment on the lumen. According to Mann et al.,[1] the internal diameter can be reduced 70 per cent before a 50 per cent reduction in blood flow takes place. The area of the lumen may be reduced 50 per cent without any change in blood flow, and be reduced as much as 90 per cent before a 50 per cent reduction in blood flow occurs. These experiments were on the carotid artery of the dog. Too much importance, however, to the roentgenologic evidence of arterial calcification should not be given. It should be properly evaluated.

* * *

The major peripheral vessels, as the dorsalis pedis and posterior tibial arteries, may be pulsating normally although the patient complains of intermittent claudication, lameness, and other symptoms of vascular deficiency. This is due to the occlusion of the smaller arteries and of the arterioles supplying the muscles of the extremities. The occlusive process can be present anywhere in the arterial system from the larger vessels down to the precapillary arterioles.

* * *

The dorsalis pedis is not palpable in its normal position in approximately 10 per cent of the cases.

1 Mann, F. C., Herrick, J. F., Essex, H. E., and Baldes, E. J.: The Effect on the Blood Flow of Decreasing the Lumen of a Blood Vessel, Surgery, 4:249–252 (Aug.), 1938.

It may curve outward, lying lateral to the line between the middle of the ankle and the back of the first interosseous space. Or it may be completely absent, being replaced by a large anterior peroneal artery. Other locations are possible.

* * *

Linear measuring of the circumference of the extremities at selected points is a good policy. Where the circulation is deficient, the tissues will be undernourished and atrophied, with a resultant reduction in circumference. Measurements will aid in checking the results of treatment and progress of the disease. These are much simpler to take than surface temperatures and oscillometer readings, and are very important in the study of the disease.

* * *

Some of the presumable symptoms of a vascular disorder—as undue tiredness, sensation of heaviness and early fatiguability in the calves, especially in the male—may be due to the onset of the climacteric. In these cases, substitution therapy may be necessary.

* * *

Do not inject or operate on a patient for varicose veins unless you are sure that the deep veins are adequate and that the patient is not suffering from a peripheral vascular disease such as thromboangiitis obliterans.

* * *

The majority of patients get better on bed rest. It is the best form of treatment and it is surprising what good results can be obtained by this method.

2007 Wilshire Boulevard.

ROY J. POPKIN,
Los Angeles.

Hemolytic Streptococcic Meningitis Treated with Sulfanilamide.—Ten of twelve patients with hemolytic streptococcic meningitis treated with sulfanilamide recovered, as compared with one of eleven patients treated with specific drugs and serums, spinal drainage, and blood transfusions, John A. Toomey, M. D., and E. Robbins Kimball, Jr., M. D., Cleveland, report in *The Journal of the American Medical Association.*

Hemolytic meningitis is inflammation of a membrane of the brain and spinal cord caused by a streptococcus capable of destroying or dissolving the red blood corpuscles.

Doctors Toomey and Kimball emphasize the fact that sulfanilamide alone may prolong the life of a patient ill with this type of meningitis, but it will not give complete cure if there is an undiscovered focus of infection. In a few cases in which the focus was not recognized immediately, the progress of the disease was held stationary. There was no cure, however, and improvement occurred only when operations eradicating the infection were performed.

The authors have not found it necessary to adopt the more involved methods used by others, but state that their procedures have given as good results. "Our practice," they assert, "has been to give a massive initial dose of the drug (sulfanilamide) followed at once by frequent maintaining doses, to have the patient operated on as soon as possible for removal of the focus of infection and to leave the fluid balance of the spine alone unless the pressure is extremely high."

A total of 102 cases described in recent literature were treated with sulfanilamide or prontosil, or both, and eighty-one of these recovered.

ORIGINAL ARTICLES

SOME INDICATIONS FOR ROENTGEN RAY TREATMENT*

By U. V. PORTMANN, M. D.
Cleveland, Ohio

PART I

THE indications for roentgen ray and radium treatment are innumerable, volumes having been written on this subject. It will be possible in this paper to give only a broad outline of the usefulness and applicability of these methods of treating different pathologic processes and to discuss a few of them specifically.

Many physicians and surgeons have neither the time nor the inclination to peruse radiologic journals. Therefore, they may not be familiar with the advances made in the technical procedures or the most recently proved indications or benefits which may be derived from irradiation for certain diseases, so they must depend for this information upon conference with their radiologist colleagues.

The medical world has become so statistics-minded that sometimes there is skepticism about the benefits of a therapeutic procedure as compared with others, unless mathematical proof substantiates the effectiveness of a newer method advocated. Definite palliative effects and improvements may be brought about in the economic status of patients by certain methods of treatment, but often cannot be calculated by any mathematical formulae. So it is with irradiation, which has proved to be of so great value in the treatment of many pathologic conditions that it no longer needs defense, although sometimes its benefits cannot be measured.

There was a time, not many years ago, when there was confusion in the minds of radiologists and disagreement about the indications or preferences for either roentgen ray or radium in the treatment of various conditions. Differences of opinion lead to progress, however, and experience and experiment prove that both the roentgen ray and radium have their own spheres of usefulness; that the rays have the same physical and biologic effects; that the use of either or both depends largely upon availability, the ease of application, or whether treatment must be given to small or large areas. The biologic reactions to both types of rays depend upon their power to modify or completely destroy cellular functions, according to the quantity and rate of administration. Each may be effectively employed alone for different and similar pathologic conditions, and more often in combination, or sometimes to supplement surgical procedures either before or after operation.

It may be said, in general, that roentgen ray and radium treatment is indicated and useful (1) for some benign tumors; (2) for most malignant tumors; (3) for many acute and chronic inflammatory processes; (4) for certain diseases that have not yet been proved to be either inflammatory or

* Guest Speaker's paper. Read before the third general meeting of the California Medical Association at the sixty-eighth annual session, Del Monte, May 1-4, 1939.

neoplastic; and (5) to modify glandular functions that are abnormal.

It is not my purpose to discuss radium treatment except coincidentally; rather, I shall limit my remarks to some of the indications for roentgenotherapy in the hope of stimulating interest in the investigation of the application of this method of treatment for pathologic conditions in which it has not been tried or has failed—possibly because techniques which had been employed were faulty. No statistics will be presented, technical procedures will not be discussed, nor will the use of roentgenotherapy in dermatology be given consideration.

BENIGN TUMORS

Irradiation is indicated for but few benign tumors, because most of them are composed of highly differentiated tissues that approach normal; therefore, they are relatively resistant to the direct destructive effects of the rays. However, there are some that are especially amenable to irradiation, among them being hemangiomas in any location and especially those of children, endometrial transplants, fibromyomata of the uterus, papillomas in certain locations, giant-cell tumors of the bone and certain benign tumors of the endocrine glands, the abnormal functions of which may be modified.

Small superficial hemangiomas that are seen in infants probably are best treated with applications of radium, and it is easier to apply to uncontrollable children. Treatment should be given as early in life as possible. Occasionally quite large hemangiomas occur for which it is impractical to use radium because of their extent. Most of these, in children, may be very successfully treated by roentgen rays. However, those in adults seldom are benefited.

Strictly speaking, endometrial transplants (endometriosis) may not be considered as benign neoplasms. Endometrial tissue may become implanted on the pelvic peritoneum and increase to such an extent that a considerable area may be involved; or they may be quite as circumscribed as a tumor. The condition may result from intra-uterine or ovarian operations, following pregnancy, or endometrial tissue may become implanted by contamination of abdominal wounds when the uterus is opened during operations. At the time of menstruation, transplanted endometrial tissue becomes engorged with blood, just as does the endometrium of the uterus. When this occurs it may cause considerable discomfort from pressure. The condition is successfully treated by stopping ovarian function permanently or temporarily by roentgenotherapy according to individual indications.

The indications and contraindications for irradiation for uterine fibromyomata are now generally agreed upon:

1. When hemorrhage is severe, either hysterectomy or radium treatment are preferred to roentgenotherapy. Radium, when applied within the uterus, has a direct effect upon the endometrium and usually will stop bleeding quite promptly before suppression of ovarian activity or the tumor *per se* is affected. Roentgen treatment stops ovarian function and directly affects fibroid tumors and endometrium, but these reactions are delayed. Usually one menstrual cycle ensues even after adequate roentgenotherapy, and this sometimes may be incapacitating. However, when it is not urgent that the hemorrhage be stopped, then roentgen treatment is preferable because of the ease of application, hospitalization and operative procedures are avoided, and during the course of treatment the patient may carry on her usual activities.

2. Women in the child-bearing ages up to forty should not receive irradiation, but should be operated upon to preserve ovarian function, unless there are contra-indications to operation because of concurrent diseases which would make surgical procedures unduly hazardous.

3. Fibroid tumors that present evidences of marked degeneration should be removed, although the presence of moderate pelvic inflammation does not contra-indicate irradiation for fibroids; in fact, this condition will be benefited if the treatment is given with discretion.

According to the experiences of radiologists, approximately 90 to 95 per cent of fibromyomata that have been irradiated have been clinically cured. Over a period of almost a year, the tumors slowly reduce in size. Sometimes vestiges of the tumor may be found even after adequate irradiation, although the symptoms have been entirely relieved by treatment. This, however, does not indicate that the treatment has been a failure, because the mere presence of the small remnant is of no clinical significance and its removal is unnecessary.

Papillomas of the larynx may recur repeatedly after operations; but, especially in children, they may be treated successfully by roentgenotherapy. Papillomatous tumors or papillomatosis of the urinary bladder also may yield to intensive treatment. We have seen cases in which the distressing symptoms have been entirely relieved and the tumors have disappeared completely.

Many giant cell tumors of bone have been successfully treated. These tumors are primarily benign, but occasionally one degenerates to become malignant. The objective of roentgen treatment is not to destroy the tumor cells, but to inhibit their growth sufficiently to permit normal osteogenic reactions; therefore, the treatment is given in relatively moderate dosages. Overenthusiastic or poorly timed treatment may stop osteogenesis which has developed and defeat the purposes of the treatment. In addition, deforming, unsightly tumors in such locations as in the bones of the lower radius and ulna or the ankle probably should be operated upon primarily, especially in women, because they are accessible and the unsightly tumor mass still may remain after irradiation.

MALIGNANT TUMORS

It would be presumptuous of me to talk here in California about the latest developments in roentgenotherapy for malignant diseases where physicists and radiologists have led the world in laboratory and clinical researches, and have developed apparatus the like of which is available in but few medical centers. When these workers began their investigations in the treatment of malignant

neoplasms, they knew (1) that tissues vary in their resistance or sensitivity to roentgen rays, and (2) that any neoplastic tissue may be completely destroyed by irradiation if a sufficient intensity can be administered without damage to normal, physiologically essential structures. (3) They hoped, also, that they might improve the quality and increase the quantity of radiation that can be administered safely and thereby improve the results. All of you are familiar with their invaluable contributions to the science of radiology.

It would be impossible even to enumerate the indications for roentgen-ray treatment of the various types of malignant tumors in different locations. I believe that, at this time, except for superficial tumors, irradiation is indicated in the treatment of malignant tumors only when there is no possibility of cure by operation or intensive radium treatment of localized neoplasms. There is considerable difference between "operability" and "curability." There are but few locations in the body where malignant tumors occur that operations cannot be performed from the technical standpoints, but this does not necessarily mean that cure may be effected or operations justified. Experienced, conscientious surgeons will not subject patients to surgical procedures if there is no possibility of cure, with the occasional exception of those cases where it is used solely for palliation. The clinical manifestations of "incurability" should be sought and recognized, and patients having them should not be operated upon, but should be treated by irradiation if the physical condition warrants any attempt at treatment. A very large proportion of patients with malignant tumors are "incurable," although operations may be performed upon a great many of them. Such practice should be condemned.

There are some conditions for which preoperative irradiation may be indicated, but probably these are very few. For tumors that offer a reasonable degree of assurance that they can be safely and completely removed, operations offer the quickest and most certain method for cure with some very definite exceptions. Those which present clinical evidences that they are too extensive to be removed completely should be irradiated. If a neoplasm can be completely destroyed by irradiation, operation following the treatment would be useless. When a malignant neoplasm has been irradiated because it is extensive and the treatment fails to eradicate it completely, then it will still be of the same extent after treatment, although possibly of less bulk, and it still would not be removable; therefore, operation at this time also could not effect a cure.

On the other hand, there are many indications for roentgenotherapy following operations, the treatment being given in order to delay or prevent extension of a malignant neoplasm if there is any doubt whatever that it has not been completely removed. This is true in a very large proportion of cases even after what appears to be adequate operations. Irradiation should be given as soon as possible before further extension takes place. It is illogical to wait until recurrences or metastases do develop, as has been advocated, before giving irradiation when there is every indication that malignant tissues remain after operation. Certainly surgeons, themselves, condemn the practice of procrastination in the treatment of cancer, and radiologists should do the same. However, when postoperative recurrences and metastases do develop they may be effectively treated by irradiation for amelioration of distressing symptoms and to prolong life and economic usefulness if possible.

In passing judgment about the benefits of roentgenotherapy for cancer in any location, it should be borne in mind that the results of this treatment for postoperative recurrences or metastases cannot be justifiably compared with other methods of treatment employed for primary tumors. There are not a few reports in the medical literature by individuals apparently unfamiliar with radiological procedure, and in which the results of operation alone for malignant tumors in certain locations are purported to be compared with the results from postoperative roentgenotherapy, and the conclusion is drawn that the treatment has not been of benefit. A careful analysis of the statistics on which this conclusion is based will show that the series of irradiated cases will contain a larger proportion of advanced cases than the nonirradiated and also some irradiated some time after operation primarily for postoperative recurrences or for metastases. Conclusions based upon such inequitable comparisons are not justifiable. As has been mentioned previously, palliative benefits cannot be calculated.

I should like to dismiss the subject of indications for the roentgenotherapy for malignant tumors with the suggestion that the best way to find out about the indications or limitations for any particular case is to consult a competent radiologist.

ACUTE INFLAMMATION

Roentgenotherapy offers a large field of usefulness in acute inflammations in many locations. This treatment usually gives prompt relief from pain, fever often abates, and the natural course of the process may be aborted.

Very soon after roentgen rays were discovered it was theorized that they might be a component of sunlight. Heliotherapy had been used for the treatment of tuberculosis, and sunlight was known to be mildly germicidal. Therefore, cultures of tubercle bacilli and other pathogenic organisms were subjected to roentgen rays, but eventually it was proved that the rays are not directly germicidal. Nevertheless, infectious processes were benefited. Perhaps the best explanation of the effects was given by Dr. Arthur Desjardins. According to his theory the effects are due to the destruction of the particularly radiosensitive leukocytes, especially lymphocytes, that infiltrate about an inflammatory process. It is thought that when phagocytic blood cells are destroyed by irradiation, antibodies and other protective substances which these cells contain are liberated to overwhelm infection. The roentgen-ray treatment of acute inflammation, therefore, requires few and small doses; in fact, large doses are deleterious.

Roentgen-ray therapy is indicated for furuncles, especially those that develop in the nasal and audi-

tory canals, and on the upper lip. In the latter location, furuncles are particularly dangerous, and incisions are contra-indicated because of the character of the venous circulation directly to the base of the brain, and the hazard of serious intracranial infection.

Carbuncles seldom should be treated surgically, but rather by roentgenotherapy and other conservative measures. This statement may seem iconoclastic and heresy, especially to surgeons, but these lesions are usually draining. The natural resistances to the infection necessary for healing are enhanced by irradiation; pain is relieved, and no scarring ensues, such as must result from surgical excision.

Some acute inflammations of the eye and eyelids yield promptly to roentgenotherapy. The small doses employed will not damage the lens, but treatment should be given cautiously to young children.

Sinusitis and mastoiditis treated in the early stages usually will be aborted and the necessity for more radical procedures obviated, and lymphoid tissue in the nasopharynx that may remain or develop after adenoidectomy and tonsillectomy often will disappear following irradiation.

Acute parotitis is one of the complications which may follow operations, especially those upon the colon. The mortality rate is high. Irradiation in the early stages is effective in controlling the inflammation; it relieves the pain and fever, and has been shown to reduce the mortality rate. Roentgenotherapy usually is preferable to radium because of the ease of application; however, radium packs will be just as effective and sometimes more convenient when patients cannot be moved.

Parotid fistulae develop when Stenson's duct is severed by accident or surgical incision. A great many operations have been devised to repair the duct when severed, but they are usually unsuccessful; the drainage of saliva from these fistulae is very troublesome, especially at meal time. Almost always the gland is infected and painful. Having observed that the function of the salivary glands is suppressed by irradiation, some years ago we deliberately tried to suppress the function of the parotid gland when fistula was present, and that repeated operations had failed to cure, in order to reduce the inflammation and by stopping the production of saliva to permit the fistula to heal. In every case prompt relief of inflammation and pain has followed treatment, the drainage ceased, the fistula closed and the function returned in three or four months; and there has been normal excretion into the mouth.[1]

Probably one of the most recent developments in the use of roentgenotherapy for a specific infection has been in the treatment of gas gangrene. One of the latest reports was made by Dr. James F. Kelly,[2] who has made an intensive study of the subject. The infection by the bacillus of Welch occurs occasionally in accidental wounds; therefore, institutions with large accident services not infrequently encounter this fatal complication. Roentgenotherapy given early is almost a specific, and has reduced the mortality rate, shortened convalescence, and obviated the necessity and hazard of surgical procedures.

We have recently become interested in the treatment of the acute and subacute encephalitis, which sometimes are sequelae of measles, influenza, and other similar diseases, and also encephalitis lethargica. Roentgenotherapy for epidemic encephalitis probably was first tried with reports of benefit as early as 1929. Since then others have employed the procedure and made contradictory reports. The results of some experimental work upon animals also has been published. The chief difficulty in interpreting the results is that the clinical diagnosis is not easy, the signs and symptoms are varied and sometimes obscure, and tend to disappear spontaneously. However, patients whom we have treated have improved, in the judgment of the clinicians. The signs and symptoms, including headaches, palsies, diplopia, and even oculogyric crises, have disappeared promptly in cases in which there was reason to believe the diagnosis was correct. The various chronic forms, including Parkinson's disease, have not shown improvement.

It may be very much worth while to give roentgenotherapy to the spinal root ganglia for patients with thrombo-angiitis obliterans. One of our patients was treated over five years ago; his toes, which were gangrenous, healed, other evidences of the disease disappeared, and he has carried on his usual activities since, four months after treatment was given.

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(To Be Continued)

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WATER ABSORPTION FROM THE COLON AND ITS RELATION TO MOTILITY*

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THIS paper will bring nothing new to the physiologist, but the subject is being called to your attention, as roentgenologists, for its application in routine studies of the colon.

It is well to remember that, primarily, it is the function of the colon to remove water from the bowel residue, particularly in the proximal portion, where the content is mushy in consistency. This bowel content should have a normal p^H threshold of 7.2 and a specific gravity of water, with the water content at 70 per cent.

The colon itself, which floats in the abdomen, has both peristaltic and antiperistaltic movements, as well as churning, mixing and mass movements. The major peristaltic and antiperistaltic movements take place chiefly in the proximal bowel, and all of these actions are either enhanced or diminished by the change in the water content of that of the residue.

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* Chairman's address. Read before the Section on Radiology of the California Medical Association at the sixty-eighth annual session, Del Monte, May 1–4, 1939.

TABLE 1.—*Percentage Relationships*

	Cases (160)	First Examination		Second Examination		Remarks
		Motility Hours	Average Per Cent Water	Motility Hours	Average Per Cent Water	
1. ADHESIONS						
Proximal colon (above cecal pouch)	10	60	78	49	70	
Midcolon (postoperative)	10	51	73	48	70	
2. ULCERATIVE COLITIS						Return to normal. Probably due to limited involvement in proximal colon. No change because of extensive involvement.
Amebic	26	18	82	38	68	
Bargans	6	20	76	46	69	
Tuberculous (advanced)	2	16	84	18	84	
3. MUCOUS COLITIS (no germ isolated)	22	19 (6-26)	88	44	73	
4. DIVERTICULOSIS (proximal colon)	18	72	60	49	70	Retention in the diverticuli a minimum of 10 per cent in the bowel.
5. DIVERTICULITIS (proximal colon) 4 clinical 2 surgical	6	78	64	50	70	
6. CONSTIPATION	40	84 (74-84)	32	49	70	All over 72-hour evacuation time.
7. IRRITABLE COLON	20	21 (6-24)	80	47	70	

The more irritating the content of the bowel, the more rapid will be its movements and its final emptying, inasmuch as the increase of the mucus content over the normal hinders the more than normal absorption of water and thus increases peristalsis. The best explanation of this phenomenon is that mucus acts as a regulator or absorber even though the cells secreting mucus have no nerve fibers.

Water is never free in fecal matter, but held in chemical combination with the colloidal particles by a peculiar property known as imbibition.

Without reviewing the extensive experimental work done by physiologists in this field, allow me to outline a minor attempt, by myself, after isolating the colon and then obtaining the absorption values of innumerable foods and drugs, to evaluate the relationship of the water content of the bowel to motility.

AUTHOR'S STUDY

Two hundred and thirty cases have been observed, with a stool study on each case as to water content of the barium mixture used from the first to the last evacuation. Only four cases must be removed from the group because of such marked dryness of the final, retained material in the terminal bowel, that interference was necessary to relieve the patient. This difficulty occurred early in the series and probably will not recur in the light of our present methods of examination. The two hundred and thirty cases mentioned were those in which the entire upper gastro-intestinal tract, including the gall-bladder, were found to be free of all pathology, and a forty-eight-hour emptying time of the entire gastro-intestinal tract was deemed to be normal. In these cases the entire ingested meal was found in the colon at twenty-four hours, the distribution varying with the pathology. Forty cases showed an average water content, of the entire evacuated meal, of 71 per cent and no colonic pathology. The age period ranged from twenty-two to sixty years, with practically no relationship to the observations. All outside stimuli, such as nervousness and drugs, were eliminated as completely as possible. The remaining 186 cases showed a water variation of from 22 to 98 per cent, depending on the pathology, and later verified by either surgery or medical interference, and a recheck in 160 cases of the 186 cases, by laboratory evaluation of the water content and its return to approximately 70 per cent, as well as a gastro-intestinal study showing normal motility.

Thus Table 1, dealing with 160 rechecked cases, may be of some value in aiding a diagnosis of colonic pathology in its relation to the changed water content; remembering only that pathology in the sigmoid and rectum do not affect the water percentage, inasmuch as absorption only takes place in the proximal one-half. This is likewise true of appendiceal pathology without adhesions, in which there is present no ascending bowel involvement.

COMMENT

The most striking observation is that of markedly increased motility in the presence of the inflammatory processes; the irritation causing a marked increase in the mucus and consequent increased water content.

From everyday observation it is recognized that a diarrhea has an increased water content of the stool that is obvious, but the majority of the patients considered in this group showed not only the diminished consistency usually seen, but a sharply increased water content by actual measurement. This point was particularly evident in the twenty-two cases of mucous colitis, where the greatest percentage of water content was associated with the obviously great amount of mucus. In all other inflammatory processes, the patients, themselves, invariably mentioned the sensation of the presence

of mucus; and even though the amount was actually less, the water content still remained high and in direct proportion to the amount of mucus.

Thus, conversely, in the largest group of forty, where constipation was the only finding, there was present no mucus in the majority of cases, and so of necessity an average of less than one-half the normal water content.

It can be seen from the table presented that the water content of the bowel has a definite relationship to the pathology of the proximal portion of the colon, with the suggestion that when such a change is correlated with motility, it may be of value in suggesting a diagnosis and thus aid the internist in eliminating the causes of the excess or lack of mucus present.

Of all the normal food products ingested, it has been found that starch will act as the chief agent in the increase of mucus and thus stabilize the water content.

We have had a practice of adding two heaping tablespoonfuls of cracker or bread crumbs to the malt and barium meal, with just that one purpose in mind, and have found it eminently satisfactory.

Since the water content is in direct proportion to the amount of mucus present, and the latter also is in direct proportion to the motility, with the exception of the twenty cases of adhesions first mentioned, the thought is suggested that, with a heavy starch intake in the barium meal, a more thorough study of the motility of the colon could be made.

1930 Wilshire Boulevard.

PHARYNGO-ESOPHAGEAL DIVERTICULA*

MODIFIED TECHNIQUE FOR ONE-STAGE OPERATION

By JOHN HUNT SHEPHARD, M. D.
San Jose

DISCUSSION *by Charles S. Roller, M. D., Woodland; F. B. Settle, M. D., Long Beach.*

DIVERTICULA of the esophagus have been recognized for over a hundred years. In 1840 Rokitansky described two types, and classified them into pulsion diverticula—those developing as the result of internal esophageal pressure; and traction diverticula—those resulting from the contraction of inflammatory tissue adjacent to the esophagus.

PATHOLOGY

Traction diverticula usually occur in the middle and lower third of the esophagus, and only rarely give rise to severe symptoms, though often cause a mild sensation of choking or a paroxysm of coughing during eating.

Pulsion diverticula practically always arise from the posterior wall of the pharyngo-esophageal junction, opposite the cricoid cartilage, where defective development of the muscles results in a weakened area. They are, in reality, hernias of the submucosa and mucosa, through this area poorly protected by muscle. They develop very slowly and usually give a history of several years of throat irritation or dysphagia.

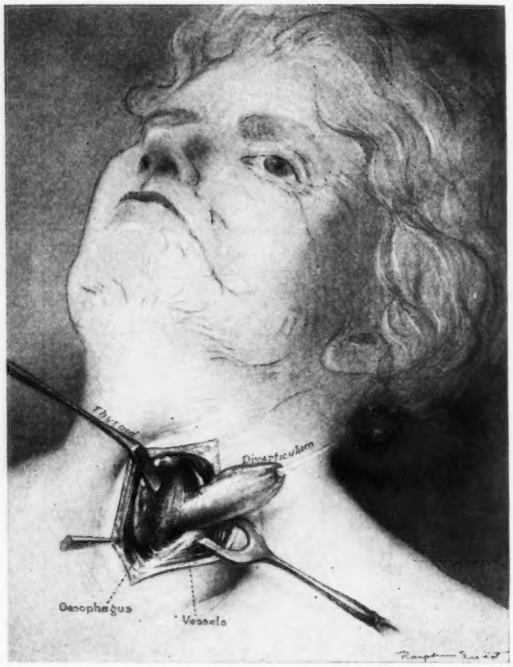

Fig. 1.—Diverticulum delivered through incision along anterior border of the sternomastoid muscle.

On account of the relationship of the trachea, the esophagus and the fascial planes in this region, the vast majority of esophageal diverticula burrow somewhat to the left side of the neck as enlargement progresses. In extreme cases the pouch may extend well down into the mediastinum.

SYMPTOMS

The first symptom noted is the sensation of particles of food lodging in the throat, relieved by a few sips of water or a little coughing. As time passes, this becomes more frequent until it is of daily occurrence. Next, the patient notes a full feeling in the throat after taking food, especially liquids, and pressure on the throat, especially on the left side, or various movements of the head and neck will cause some food to be forced into the throat. When the pouch attains sufficient size to hold an ounce, pressure on the left side of the neck, immediately after drinking water, will cause it to be returned to the throat with a peculiar audible sound.

In the presence of a large diverticulum, almost complete obstruction of the esophagus may result. The patient may have spent the greater part of his time in eating and regurgitating in order to sustain life.

While the symptoms may be very suggestive of a diverticulum, the final diagnosis is made by the x-ray and the esophageal bougie.

DIAGNOSIS

Films taken immediately after the administration of an aqueous suspension of barium reveals the pocketing of the barium in the diverticulum, out-

* Read before the General Surgery Section of the California Medical Association at the sixty-eighth annual session, Del Monte, May 1–4, 1939.

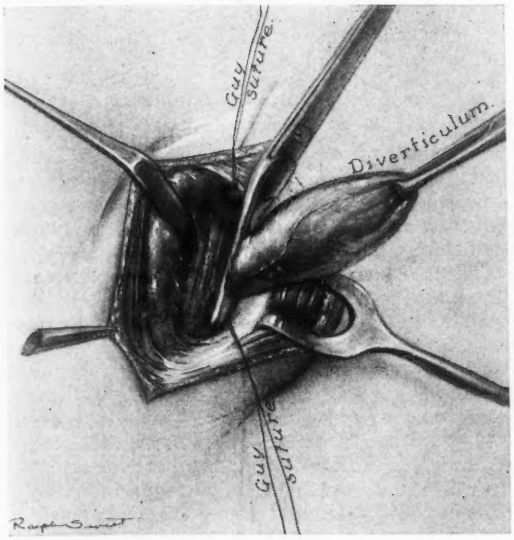

Fig. 2.—Guy sutures in place and special clamp applied to neck of diverticulum.

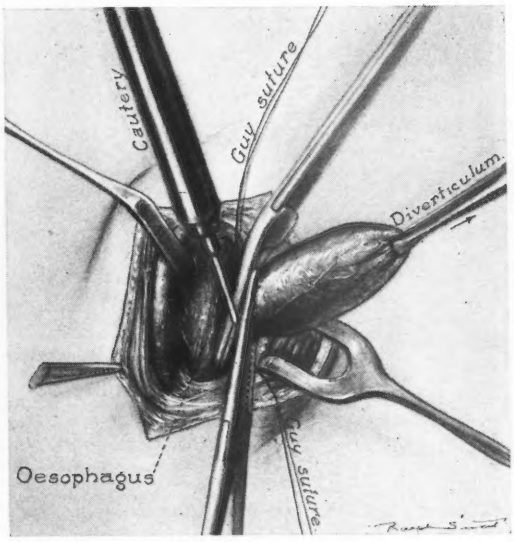

Fig. 3.—Diverticulum being cut off with cautery.

lining its size and position. The only lesion with which it may be confounded is dilatation of the esophagus above an organic stricture.

There is one contraindication to the administration of barium to patients complaining of dysphagia. It is the occasional presence of a tracheo-esophageal fistula, and it is the clinician's obligation to at least suspect its presence and warn the roentgenologist of its possibility; for if barium enters the lung, pneumonia usually follows.

When the x-ray reveals evidence of interference with the normal passage of the barium, the patient should be instructed to swallow two yards of a fine silk thread on each of two successive days. While some of the thread may lodge in the diverticulum, it will find its way down the esophagus through the stomach and become anchored in the coils of intestine. A perforated olive, attached to a flexible tip on a whalebone bougie, is threaded on the silk thread and passed through the pharynx, entering the diverticulum, and meeting obstruction at the bottom of the pouch. The position of the teeth on the whalebone shaft is noted. The string is then drawn taut, causing the bougie to elevate. When pulling on the string causes no further elevation of the bougie, the position of the teeth on the whalebone staff is again noted. The difference in the change of the position of the teeth on the staff gives the depth of the diverticulum. With the string then held taut, the bougie can be passed down the esophagus into the stomach.

When the pocketing of the barium is in a dilated esophagus above an organic stricture, this change in the position of the bougie does not occur. While such a lesion is rare, it should be ruled out before a positive diagnosis of pharyngo-esophageal diverticulum is made.

TREATMENT

The first step in the treatment of all lesions of the esophagus, requiring the passing of bougies, is the establishment of the "string guide," introduced by Mixter and frequently emphasized by H. S. Plummer. It is surprising how the silk thread finds its way through even a very tight stricture. After passing through the stomach, it becomes anchored in the coils of the intestine. When pulling up the slack from the esophagus and stomach immediately prior to instrumentation, the tip of the index finger should be placed beneath the string at the base of the tongue to protect it from being irritated or even cut by the string.

In large, long-standing diverticula, the patient's nutrition may be very poor, and two or three weeks of tube feeding may be necessary before operation. With a hot wire a guide-hole can be burnt from the tip to the eye of a 22-F soft rubber catheter. By threading this over the string, and holding the string taut, the catheter can be introduced down the esophagus past the diverticulum and the patient fed through the catheter. Following the operation, feeding can thus be continued; but a 14-F catheter should be used.

Anesthetic.—Cervical block anesthesia, with local infiltration along the line of incision, is most satisfactory.

INITIAL OPERATIVE PROCEDURES

An incision along the anterior border of the sternomastoid muscle, or an oblique incision one and one-quarter inches above the clavicle, extending from the posterior margin of the sternomastoid muscle to the midline of the neck, may be used.

The sternomastoid and anterior belly of the omohyoid muscles, and the carotid sheath, are retracted laterally. The sternothyroid and sternohyoid muscles and the lateral lobe of the thyroid gland are retracted mesially. At times a branch of the inferior thyroid vessels may have to be severed. The diverticulum will be found lying against the posterior wall of the esophagus and projecting slightly to the side. If it is not readily located, a soft rubber catheter may be passed through the

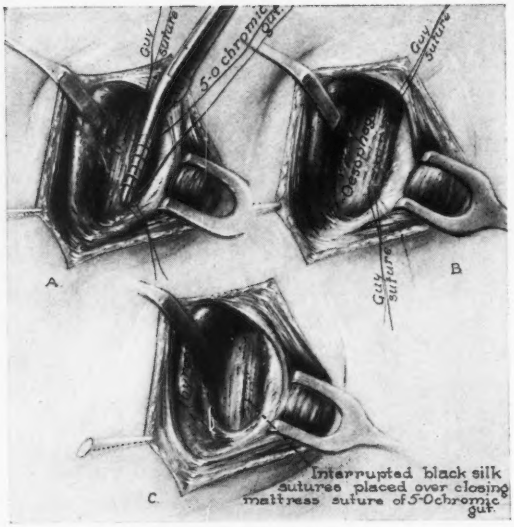

Fig. 4.—Method of closure after diverticulum is cut off.

pharynx into the diverticulum, making it easy of identification. Careful blunt dissection frees the diverticulum and its neck, or communication with the esophagus, must be exposed in its entirety.

SUBSEQUENT OPERATIVE PROCEDURES

The following procedures for treatment of the diverticulum from this point have been recommended:

1. Excision of the neck of the sac, step by step, suturing the walls as excision progresses, followed by covering the line of suture with adventitia tissue.
2. The application of multiple purse strings, puckering up the sac into a mass along the wall of the esophagus.
3. Invagination of the sac into the esophagus and suture of the invaginated base, allowing the sac to hang loose in the esophagus.
4. Ligation of the neck of the sac. Cutting through the adventitia and submucous tissue distal to the ligature. Ligation of the mucosa and severance of same distal to the ligature. Suture of the submucosa and adventitia over the mucosa ligature.
5. A two-stage operation: The first stage, consisting of applying a ligature around the neck of the sac, or only twisting the neck one and one-half turns; bringing the sac out through the upper angle of the incision and suturing it to the skin; packing the lower part of the incision with iodoform gauze. Second stage: About one week later, removing the packing; cutting off the sac with the cautery, and partial closure of the wound.

OBJECTIVES IN OPERATIVE PROCEDURES

The objectives to be sought for in the operative cure of diverticula of the esophagus are: (1) To secure a normal contour and caliber to the esophagus, with a firm closure of the defect in the wall; (2) an aseptic technique.

Of the above methods, the first disturbs the contour and caliber less than any of the others, but offers considerable opportunity for contamination of the operative field. I wish to present a technique which I believe comes nearer to fulfilling the two objectives than any so far reported.

AUTHOR'S PROCEDURE

After the neck of the diverticulum is freely isolated and the line of excision determined, silk traction or guy sutures are placed at the upper and lower junction of the diverticulum with the esophagus. Since the operation is being performed under unilateral cervical block anesthesia, there is no danger of aspiration of any of the contents into the lungs.

A special angle clamp is then applied to the neck of the diverticulum distal to the two guy sutures, just far enough removed from the esophagus to allow for the introduction of sutures. The sac is then removed with the cautery. Though this clamp is light, it is sufficiently powerful, with the sealing effect of the cautery, to temporarily freeze the walls together, the same as a Payr clamp and cautery acts in a pylorectomy. Using 00000 chromic gut, a running suture is placed over the clamp such as used on the duodenal stump in a pylorectomy. Tightening of the suture after removal of the clamp inverts the severed surfaces, and by properly holding the guy sutures no distortion of the lumen of the esophagus occurs. Several interrupted sutures of fine silk reinforce the closure, and the fibers at the lower level of the constrictor muscles of the pharynx can be used to reinforce the area.

While I believe primary closure of the incision is perfectly safe, a small Penrose drain should be inserted until further experience proves or disproves the aseptic efficiency of this technique.

SUMMARY

1. A brief discussion of the diagnosis of esophageal diverticula.
2. Attention is called to various operative procedures for their treatment, and a description of a modified technique for a one-stage operation.

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DISCUSSION

CHARLES S. ROLLER, M. D. (Woodland Clinic, Woodland).—Doctor Shephard's operation, in first carefully freeing the neck of the sac, placing guy sutures, using special clamps, removing the sac with the cautery, and then using a running inverting suture, theoretically removes the diverticula and seals the neck of the sac without contaminating the mediastinum. Further interrupted sutures of silk, utilizing the fascia and the lower fibres of the constrictor muscles of the pharynx, complete the closure. A drain is very wisely inserted.

This operation in one stage requires a maximum of surgical skill and meticulous care to insure complete closure and no infection of the mediastinum during operation. In addition, it must also insure such perfect closure and perfect suture tension that, in all likelihood, union will be primary. Unless one is certain of his technique, may I say that the two-stage removal gives most excellent results, and in the average hands may still be the safest operation. In saying this, it is with the distinct understanding that I believe definite progress will be made if, in the future, experience proves that we can safely accomplish this operation in one stage. Inflammation or diverticulitis of the sac, or a very broad neck, or insufficient tissue to insure an absolutely satisfactory closure of the neck of the sac, are, in my opinion, indications for the two-stage operation. I believe that in doing this surgery, one should not make up his mind at the start that he is going to do a one-stage

operation, but should pick the cases at operation that he believes can be done with safety to the patient by the one-stage procedure.

Aspiration and drying of the interior of the sac at operation, and lighting of the sac with the esophagoscope by an expert esophagoscopist during operation—as mentioned by Babcock and Chevalier Jackson—should be of value during this procedure.

It also occurs to me that, after separation of the sac, if it is not too large, it might possibly be inverted into the esophagus with the aid of the esophagoscopist, and the sac neck closed externally by well-placed sutures, and the sac excised from the interior of the esophagus by the esophagoscopist. Whether this is a rational procedure I do not know, but it seems that it might lessen the danger of contamination of the mediastinum, since the esophagus would be closed externally before any excision of the sac was done.

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F. B. Settle, M. D. (117 East Eighth Street, Long Beach).—Doctor Shepard's paper is very timely, since it brings to our attention a condition which is not common in private surgical practice, as a rule, the average surgeon seeing only an occasional case during the year. His comments on the etiology, the types, and the symptoms are adequate and do not require reiteration.

I concur in his diagnostic and preoperative procedures, but also believe that a direct esophagoscopic examination is of great value in determining the size of the opening of the diverticulum, the presence or absence of ulceration of the esophagus, and the possible etiological factors entering into the formation of the weakened muscular wall at the junction of the pharynx and esophagus. The swallowed string may be used in conjunction with the esophagoscope.

Doctor Shephard's modified technique for a one-stage operation is a definite contribution to the surgical treatment of esophageal diverticuli, since, insofar as I know, his use of the traction sutures is original. This method should add materially in accomplishing an asceptic operation, and in preserving a normal contour of the lumen of the esophagus. The use of a small right-angle, crushing clamp to the neck of the sac, excising the sac with a cautery and inverting the stump with a running suture, affords an ideal closure of the opening. I have used the small right-angle, cystic duct clamp in a similar manner on several occasions, and have found it satisfactory, both in the one-stage operation and in the second of the two-stage procedures.

Regardless of the method of technique I believe that the most important factor is a careful and minute freeing of the fibers of the inferior constrictor and cricopharyngeus muscles from around the neck of the diverticulum, securing good, free mucosa, thus avoiding possible sacculation which might otherwise be overlooked and cause recurrence of the diverticulum, a condition simulating the recurrence of inguinal hernia. I have also found a loop, similar to the type used by the eye-men, to be of great assistance in magnifying the field of operation.

I think that one should adopt either the one- or two-stage operation, depending upon the individual case, the condition of the patient being the determining factor. Oftentimes in elderly, emaciated patients the first of the two-stage procedures seems sufficient. This was called to my attention a number of years ago in a middle-aged man who, following the first of a two-stage procedure, was forced to leave the hospital because of death in the family. At the second operation, some six or eight weeks later, there was only a small remnant of the original sac. I have doubted the necessity of removing this remnant.

It has, of course, been noted at the second of a two-stage procedure that the sac is often smaller, contracted, and somewhat indurated. I have since followed only the first of the two-stage procedure in two other instances, the patients being apparently relieved, and refusing to submit to the second operation.

A cervical block, either alone or combined with direct infiltration, affords an ideal anesthetic. However, if the sac is difficult to locate, inhalation anesthetic and the use of an esophagoscope are of great value. I believe that a longitudinal incision along the anterior border of the sternomastoid muscle gives a freer approach, and if a two-stage procedure is selected it becomes much easier to anchor the fundus of the diverticulum well above the opening into the esophagus. This is a very important factor in establishing free drainage of the sac and permitting drainage of the lower angle of the wound when mediastinal contamination might be suspected.

I believe it very inadvisable to twist or ligate the neck of the sac in the first of the two-stage procedure, and penetration of the lining of the sac with suture should be avoided.

Prolonged postoperative feeding with a Levine tube is of great value. I have found dilatation of the esophagus unnecessary following surgical treatment for esophageal diverticuli, either in the one-stage, or following the second operation of the two-stage procedure.

GONADOTROPIC HORMONE OF PREGNANT MARES' SERUM*

ITS CLINICAL USE IN GYNECOLOGY

By George Joyce Hall, M. D.
Sacramento

Discussion *by L. F. Hawkinson, M. D., Oakland; Sheldon A. Payne, M. D., Los Angeles.*

THE announcement by Aschheim and Zondek,[1] in 1928, of the discovery of a gonadotropic substance in the blood and urine of pregnant women initiated an intensive search by other investigators for gonadotropic hormones in the body fluids of many species of animals.

In 1930 Cole and Hart,[2] of the University of California, reported, in the first of a series of papers, that the blood of the pregnant mare, between the 40th and 150th days of gestation, contained a hormone which they thought was similar to that found in human pregnancy urine.

Further papers in their series, as well as reports by numerous other investigators, notably Evans,[3] confirmed the presence of a gonadotropic hormone, but indicated that this equine gonadotropic hormone was in many respects different from the anterior pituitary-like sex hormone of human pregnancy urine.

EQUINE GONADOTROPIC HORMONE

The equine gonadotropic hormone was shown to have a characteristic biological reaction similar to that of the anterior pituitary complex itself. Administration of proper dosage to infantile female rodents produced follicle growth, ovulation and corpora lutea in the manner and sequence found in adult females; in fact, young rats (twenty-eight days old) were bred three days following an injection and became pregnant.[4]

On the administration to ewes of sufficient amounts of the hormone at proper time intervals, Cole and Miller[5] found that estrum, ovulation, and impregnation would result, following breeding during the anestrous period. They also demonstrated that it would produce ovulation in the sow, mare, and other higher animals.

Gonadotropic hormone is found during pregnancy in the blood of the human female, the mare, zebra, giraffe, and some other primates.

The primary difference between the equine gonadotropic hormone and the chorionic hormone

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* Read before the Obstetrics and Gynecology Section of the California Medical Association at the sixty-eighth annual session, Del Monte, May 1–4, 1939.

TABLE 1.—*Miscellaneous Data in 135 Cases*

Menstrual Disturbances	No. of Cases	Duration of Disturbance	Duration of Treatment	Not Improved		Improved		Cured	
				No.	Per Cent	No.	Per Cent	No.	Per Cent
Amenorrhea, primary	4	Ages 21 to 25 years	Six months	1	25.0	2	50.0	1	25.0
Amenorrhea, secondary	6	Twelve to 24 months	Four to six months	0	0.0	2	33.3	4	66.7
Hypomenorrhea (under age 30)	37	Six months to ten years	Two to eight months	6	16.0	11	30.0	20	54.0
Hypomenorrhea (ages 30 to 40)	64	Six months to fifteen years	Two to eight months	6	9.3	24	37.3	34	53.1
Oligomenorrhea	33	Six months to three years	Two to eight months	5	15.1	10	30.3	18	54.5
Menometrorrhagia	16	Three months to three years	Two to six months	1	6.25	3	18.75	12	75.0
Dysmenorrhea	32	Six months to fifteen years	Two to eight months	2	6.25	8	25.0	22	68.75

from pregnancy urine becomes evident in their effects upon hypophysectomized animals: chorionic gonadotropic hormone has little, if any, effect on the gonads,[6,7] while the equine hormone restores complete normal functions in ovaries atrophied by hypophysectomy.[8]

CLINICAL STUDY

These various animal experiments indicated that this gonadotropic hormone might be valuable for clinical use. Purification of the hormone, to a degree that it would be unlikely to produce foreign protein reactions, made its clinical use in the human possible. The extent of the purification may best be illustrated by the fact that the hormone solution contains less than one half of one per cent of the amount of serum protein found in any previous commercial serum preparation.

The series herein reported consists of 135 patients. These have been divided into three groups: (1) menstrual disturbances; (2) genital hypoplasia; and (3) sterility. A number of patients necessarily fall into more than one group. For example, a patient whose primary complaint was sterility may also have had associated dysmenorrhea or hypomenorrhea; and one who complained of the subjective symptoms of estrogen deficiency might also have had genital hypoplasia, dysmenorrhea or oligomenorrhea.

DIAGNOSIS

The diagnosis in the majority of cases is evident after a careful history and physical examination. The vaginal smear method of Papanicalaou[9] is valuable in determining the degree of ovarian deficiency, and has been used in nearly all cases as a diagnostic aid, and to evaluate the results of therapy.

Endometrial biopsies have been obtained in the majority of patients. It is difficult to correlate menstrual disturbances with endometrial studies, and my findings agree with Kotz and Parker,[10] who conclude that there are no specific endometrial patterns for gynecological symptoms. However, a study of the endometrium may be of value in determining the effects of treatment.

Sterility cases have been fully investigated. The examination included a tubal patency test, a basal metabolism rate determination, and an examination of the husband instituted before treatment.

DOSAGE

The rat unit, as suggested by the discoverers of the hormone, and described by Cole and Saunders,[11] is the amount which, ninety-six hours after a single injection, will cause the development of an average of three to ten follicles, or corpora lutea in a group of five, twenty-one to twenty-three-day old female rats.

It has been found that the ovarian weight, rather than the body weight of the animal is the criterion for determining comparative doses.[12] Ovulation is produced in the rat with one unit, the ewe with 125 units, and sow with 250 units, while 750 units are required for the cow and mare. These comparative weights suggested that 600 to 1000 rat units would be required to stimulate the ovary of the human female.

The majority of the patients in the series received 200 rat units (Cole and Saunders) of the equine gonadotropic hormone* on the seventh, eighth, and ninth days following the onset of menstruation. The average length of treatment was four months.

Estrogenic hormone was administered to all patients with amenorrhea, hypomenorrhea, oligomenorrhea, genital hypoplasia, and to some of those with sterility, previous to the treatment with the equine gonadotropic hormone. Two to ten thousand rat units of estradiol benzoate (Progynon B) were administered every three to five days during the postmenstrual and intermenstrual phases over a period of one to two cycles, or until a normal vaginal smear was obtained.

The menstrual disturbances are outlined in Table 1. It will be noted that the largest group

* "Gonadin" supplied through the courtesy of the Cutter Laboratories, Berkeley, California.

TABLE 2.—*Data in Forty-three Cases of Sterility*

Menstruation	No. of Cases	Duration of Sterility	Pregnancies	Per Cent
Apparently normal	14	3 to 7 years=4 cases 7 to 10 years=7 cases 10 to 17 years=3 cases	10	71.3
Dysmenorrhea	8	5 to 7 years=5 cases 7 to 9 years=3 cases	6	75
Hypomenorrhea	8	5 to 7 years=4 cases 7 to 10 years=3 cases 10 to 17 years=1 case	5	62.5
Oligomenorrhea	7	5 to 7 years=5 cases 7 to 10 years=2 cases	2	28.6
Menometrorrhagia	3	3 to 5 years=3 cases	1	33.3
Amenorrhea, secondary	2	5 years=2 cases	0	0
Amenorrhea, primary	1	6 years=1 case	0	0
Total cases 43		Total pregnancies 24		55.8%

comprised those with hypomenorrhea. These are divided into two age groups, and there was little difference in the response obtained. In the younger patients 54.0 per cent were cured, while in the older women 53.1 per cent were benefited.

Genital hypoplasia accompanied all cases of primary amenorrhea and one-third of those with secondary amenorrhea. Primary amenorrhea is not common, and in the four cases, whose ages ranged from twenty-one to twenty-five years, one was cured. Two were improved, but the oldest patient did not respond after six months of treatment. Of the six patients treated for secondary amenorrhea, four menstruated normally after four to six months of treatment and have maintained normal menstruation without further therapy. The two remaining patients menstruated following treatment, but have required continued treatment to maintain their cycles.

Menorrhagia and metrorrhagia are included under the term "menometrorrhagia." Where excessive bleeding is due to a persistent follicle, good results should be obtained with a hormone which is capable of follicle stimulation. Twelve women (75.0 per cent) responded to treatment by a decrease in the amount of menstrual flow to that which is commonly considered to be normal.

Regulation of the menstrual cycle was accomplished in eighteen (54.4 per cent) of the thirty-three women with irregular menstruation. These have all remained regular without further therapy during an observation period of from nine to fifteen months. Though they are menstruating regularly at the present time, the ten classified as improved have not been observed for a sufficient period to consider them permanently relieved.

Over 68 per cent of the dysmenorrheic women were relieved after the administration of equine gonadotropic hormone. It is not known at the present writing how long this relief will continue. However, twelve patients have been free from dysmenorrhea for as long as ten months without further treatment.

Seventeen patients had genital hypoplasia. Some had small external genitalia, narrow vaginas, and uteri under normal size, while others seemed normal except for uterine hypoplasia. Three of the former group were not improved. Six (35.2 per cent) were improved, but had to remain under hormone treatment to maintain regular menstruation. Eight (47.0 per cent) are classified as cured because they developed normal genitalia, had normal menstrual periods, and maintained normal vaginal smears without further treatment.

Twenty-four (55.8 per cent) of the forty-three cases of sterility became pregnant after the administration of equine gonadotropic hormone. It is noteworthy that two of these had been sterile for more than fifteen years, and both conceived and carried to term. The remainder complained of sterility for from three to twelve years. Three of the twenty-four pregnancies were lost before full term: one at six months because of placenta praevia, one miscarriage at three months, and one abortion at nine weeks. There were no fetal malformations or stillbirths.

COMMENTS

Bowes,[13] in a preliminary clinical report, has shown that 80 per cent of his cases of amenorrhea have benefited by the administration of equine gonadotropic hormone. Davis and Koff[14] have reported the experimental production of ovulation in the human female by administration of this hormone.

The physiologic production of gonadotropic hormone of the anterior lobe of the pituitary gland is gradual over a period of a number of days, allowing adequate growth and maturation of the follicle. Therefore, it seems preferable to divide the total dose over a period of several days rather than to

TABLE 3.—*Summary of Results*

	Not Improved	Improved	Cured
Menstrual disturbances	11%	31%	58%
Genital hypoplasia	17%	35%	47%
Sterility			55.8%

administer one large dose. It is possible that a higher percentage of good results may be obtained by varying the dose according to the initial response. However, in this series the hormone was used in approximately the same dose, at the same period each month, in order to evaluate this method of administration.

Two to four months of treatment is the average amount commonly required. Some patients may be benefited after the initial course of therapy, but stimulation of the ovaries for only one cycle is usually insufficient for the maintenance of normal ovarian function. Therapy, therefore, should be continued even after menstruation seems to be normal.

Many of the improved patients have not maintained normal function longer than one or two periods and have required further treatment. Also, it is not known how long some of the patients classified as cured will continue to menstruate normally.

There are a number of patients who have shown no evidences of improvement, and when the ovaries of some of these were subsequently examined at operation, they were found to be small, white, and atretic. This type has not shown improvement with any form of treatment.

Although many of the premenopausal patients have responded with normal menstrual functions, it is apparently quite useless to expect satisfactory improvement in the nonfunctioning ovaries of women at the menopause.

The amount of menstrual bleeding is not an accurate criterion for evaluation of ovarian function. The woman who uses three pads per month and the one who uses three dozen are both manifestations of lowered ovarian function. Also, a woman may use twelve pads and menstruate four days, and yet show objective signs of ovarian hypofunction. The atrophic vaginal smear, an abnormal endometrial biopsy, underdeveloped breasts and genitalia, are all evidences of underfunction of the ovaries.

Two patients have had serum reactions. Both of these had urticaria at previous times, and both developed a mild generalized urticaria after three doses of equine gonadotropic hormone. An occasional local reaction at the site of injection was noted.

SUMMARY AND CONCLUSIONS

The historical and experimental data on equine gonadotropic hormone are briefly reviewed. The fundamental differences between equine gonadotropic hormone and the anterior pituitary-like sex hormone from pregnancy urine are noted.

In a series of 135 cases which received equine gonadotropic hormone, there were 57.6 per cent cures in patients with menstrual disturbances, 47.0 per cent of those with genital hypoplasia were cured, and 55.8 per cent who were treated for sterility became pregnant.

Equine gonadotropic hormone is sufficiently free from serum protein for use in the human, and is the most valuable gonadotropic hormone thus far available for the treatment of menstrual disorders and functional sterility in the female.

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DISCUSSION

L. F. Hawkinson, M. D. (445 Thirtieth Street, Oakland).—During the past twenty months I have used equine gonadotropic hormone in ninety-three cases of menstrual disturbances and sterility. The results, too often poor, with other gonadotropic preparations made me extremely skeptical about another new product. However, the fact that this hormone had been used with marked success in the veterinary field for a period of over four years offered some hope that it would stimulate the ovaries of a human female.

My results, on the whole, compare with those of Doctor Hall. In a group of thirty-one carefully selected sterility patients, 45.1 per cent became pregnant. How many of these women would have become pregnant without treatment is, of course, unknown. However, when a woman who has been sterile for five to fifteen years becomes pregnant following one to four series of injections of equine gonadotropic hormone, it hardly seems coincidental. Over 45 per cent of the dysmenorrheic women were relieved of pain. However, four, or 13.9 per cent, of those with dysmenorrhea reported that their pain became considerably worse following treatment. All of these were patients with uterine hypoplasia.

The administration of estrogenic hormone previous to the equine gonadotropic hormone seems to be indicated in many cases. One must remember that two problems are involved: the responsiveness of the ovaries to gonadotropic stimulation, and the receptiveness of the uterus to the ovarian hormones. Estrogen seems to increase the receptiveness and, thereby, allows the estrogenic and corpus luteum hormones to exert their effect on the endometrium.

In my opinion, patients with primary hypogonadism and uterine hypoplasia should first be treated with sufficient amounts of estrogenic hormone to increase the uterus to near normal size. This eliminates the possibility of causing ovarian damage by overstimulation.

Whether or not Davis and Koff were correct in their assumption that they produced ovulation in their patients, the fact remains that there is undeniable evidence that ovarian stimulation results from the injection of equine gonadotropic hormone. Definite symptoms of ovulation, control of excessive flow, increased flow in patients with

scanty menstruation, and a change in the premenstrual endometrium from an interval type to a secretory phase, are strong evidences that stimulation of the ovaries has been accomplished. Of course, one cannot expect to stimulate ovaries incapable of functioning.

My dosage has been somewhat larger than that used by Doctor Hall. The majority of patients received 200 Cole-Saunders units or 20 Cartland units, for five doses, beginning the fourth or fifth day after the onset of menstruation. The injections were given daily, or every other day, depending upon the length of the cycle. The last dose was given before ovulation is assumed to occur.

Skin tests have not been used prior to the administration of the hormone. The necessity of skin testing seemed to be obviated after demonstrating that rabbits, previously sensitized with injections of Gonadin, showed no evidences of serum protein reaction after injection of one cubic centimeter of Gonadin intravenously.

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SHELDON A. PAYNE, M. D. (921 Westwood Boulevard, Los Angeles).—We may rightly conclude from Doctor Hall's work that the gonadotropic hormone from the serum of pregnant mares is the most potent hormone of that kind available, and that some of the results may be spectacular. Also, in obtaining such unusually good results, it is apparent that Doctor Hall not only has had at his disposal a more potent endocrine preparation, but that his cases have been selected with considerable care. Only by careful discrimination can the results of such therapy be evaluated.

Before deciding on treatment it is only logical to attempt to determine the gland primarily at fault. Hormone assays and endometrial biopsies are valuable aids in diagnosis. In cases with ovarian failure, the endometrial biopsy is almost indispensable in evaluating treatment, since the ovarian activity is mirrored in the endometrial picture. The test for urinary pregnandial is helpful in determining ovulation.

In the treatment of menstrual dysfunctions we have found it necessary, in many cases, to use more intensive therapy than reported here, hence many of our patients received 200 to 400 Cole-Saunders rat units three or four times a week for several weeks. This more intensive therapy seemed to be indicated, since, in many instances, the endometrial biopsies, while under treatment, showed an arrested estrin or persistent estrin effect, even though several were enjoying regular uterine bleeding. In some of these cases the endometrium later became secretory. Dysmenorrhea was commonly associated with the anovulatory cycles, disappearing when a secretory type of premenstrual endometrium became established. It is coming to be recognized more and more that anovulatory cycles are very common in young girls as the menstrual cycles are becoming established, and we feel that this process may be reproduced by treatment. Some patients respond very quickly to the mare's serum hormone, the endometrium changing from an atrophic, persistent estrin, etc., to a secretory type during the first menstrual cycle.

Many of Doctor Hall's patients received considerable estrogenic treatment the month or two before gonadotropic hormone was given. Since estrogenic substances alone have been used in such cases with some degree of success, one might question, in evaluating the results, what rôle the estrogenic substance had played?

There is no doubt that the mare's serum hormone is a potent ovarian stimulant. It offers new hope in the treatment of genital hypoplasia, in the treatment of menstrual disturbances, and particularly in the treatment of sterility due to failure of ovulation. However, our enthusiasm should be tempered by our experience with other gonadotropic hormones, which have come with great promises from the experimental laboratories, but have fallen under expectations when put to the clinical test. There is still much experimental work to be done, and the method of administration, the dosage and dosage intervals, etc., are yet to be determined.

SULFANILAMIDE AND SULFAPYRIDIN IN THE TREATMENT OF VARIOUS INFECTIONS*

FACTORS INFLUENCING PROGNOSIS IN PNEUMONIA

By CHESTER S. KEEFER, M. D.
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PART II†

IN appraising the results of sulfanilamide and sulfapyridin therapy, it is well to remember the various factors concerned in the prognosis of pneumococcic pneumonia. There are so many variables that are operative in this disease that it is exceedingly difficult, on a basis of gross fatality statistics, to be certain that any form of treatment influences either the course of the disease or the fatality rate even when large numbers of cases are studied. One should include all cases in any study, and then break down the statistics and explain the deaths rather than exclude certain cases at the outset. If one singles out and analyzes various factors in treated cases, and compares the results in cases presenting comparable features without treatment, then certain opinions can be developed concerning the value of any form of treatment. In any case, it is necessary to correlate the variables and determine whether or not the particular form of treatment has reduced the fatality rate or altered the course of the disease in a significant number of cases before one can be certain that the particular form of treatment has been responsible for any difference.

In assessing any group of cases of pneumonia, then, it is necessary to take into account the following factors, which are known to influence both the fatality rate and the duration of the illness. They are listed in Table 2.

TABLE 2.—*Significant Prognostic Factors in Pneumonia*

1. Age
2. Bacteremia
3. Type of pneumococcus and their relative frequency in any group
4. Race and type of work
5. Number of lobes involved
6. Leukocyte count
7. Focal infections
8. Debilitating diseases
9. Mixed infections
10. Pregnancy
11. Alcoholism
12. Miscellaneous features
    a. Degree of cyanosis
    b. Delirium
    c. Abdominal distention
    d. Jaundice
    e. Pulmonary edema

Of all the factors listed in the table, the three most important are (1) the age of the patient, (2) bacteremia, and (3) the type of infecting

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Guest Speaker's paper, read before a joint meeting of the sections on General Medicine and General Surgery of the California Medical Association at the sixty-eighth annual session, Del Monte, May 1–4, 1939.

† Part I of this paper appeared in the August issue of CALIFORNIA AND WESTERN MEDICINE, on page 81; discussion comment on "Results of Treatment of Pneumonia with Sulfapyridin," in the same issue, on page 143.

TABLE 3

	Total Cases	Total Number of Cases		Per Cent Bacteremia	Per Cent Fatality
		Under 40	Over 40		
Clinic A	1,456	1,003	453	17.0	19.0
Clinic B	1,879	1,052	827	19.0	28.3
Clinic C	1,586	678	908	36.7	46.2

pneumococcus. The other factors are significant, but in many cases they are only accompanying features. In analyzing gross fatality rates in treated and untreated patients, it is absolutely essential to know about all of the above factors and, in particular, the three just mentioned. Analyses of cases as presented by Finland, Bullowa, Cecil, Robertson, Cole, Cohn, and their associates, and many others, serve to stress this point. When the fatality rates, which are reported by different observers, are compared on a basis of the above phases, it is possible in most instances to reconcile the wide divergences in death rates that are often reported. Inasmuch as the afore-mentioned factors often influence the outcome of the disease, they require commment.

Bacteremia.—The important points to remember about bacteremia in pneumonia are as follows:

It increases in frequency with advancing age, so that it is about three times as frequent over the age of 40 as under 40.

It is always of serious importance regardless of the day of the illness on which it is detected, since the fatality rate is three to four times as high in bacteremic patients as it is in those without bacteremia.

While it is always of serious prognostic importance, regardless of age, more patients recover with bacteremia under 40 than over 40 years of age.

It is found most often in patients with Types II, V, and I (20 to 40 per cent) and less often in Types III, VII, and VIII. The highest fatality rates with bacteremia are encountered in Types III, VII, V, I, II, and VIII, respectively.

It is encountered more often when there are multiple lobes involved, leukopenia, severe abdominal distention, deep cyanosis, delirium, and pulmonary edema, than it is without these features.

At the Boston City Hospital the incidence of bacteremia is approximately 36 per cent of all cases. In other large series of cases it is lower (17 to 20 per cent). This must be taken into account in assessing fatality statistics from various clinics.

The fatality rate in bacteremic cases varies from 25 to 100 per cent, depending upon age, and from 50 to 98 per cent, depending upon type.

Bacteremia is always more serious when accompanying bronchopneumonia than it is in lobar pneumonia.

The incidence of bacteremia is higher in patients with preëxisting systemic diseases.

Bacteremia is at least twice as frequent in patients who develop postpneumonic focal complications as it is in a nonbacteremic group.

Bacteremia is less frequent in patients who are treated with serum than in those who do not receive serum treatment.

In general, it can be said that, of the bacteremic patients recovering without treatment, the number of colonies of pneumococci in the blood is less than 10 per cubic centimeter. If the number of colonies increases in successive blood cultures, or if the blood culture is positive more than once, the prognosis is worse than if there is a single positive blood culture with a small number of organisms.

While the fatality rate increases with advancing age in the nonbacteremic cases as well as the bacteremic cases, it rises much more abruptly after the age of 50 years. Under 50 years, it is approximately 15 per cent; over 50 years it is about 55 per cent.

In brief, one can say from the experience with large numbers of cases of pneumonia that, regardless of the treatment employed, *the lowest fatality rates will be found in patients without bacteremia, and especially in individuals without bacteremia who are under forty years of age.*

Age.—Of the highest importance in the prognosis of pneumonia is the age of the patient. By common consent, the greatest number of deaths from pneumococcic pneumonia occur over the age of 40 years, and the death rate definitely increases with age. The lowest death rate is observed between the ages of 2 and 11 years, but from then on it increases from about 8 to 85 per cent from the ages of 12 to over 70. The reasons for the increase in the death rate with advancing age are numerous and not completely understood, but the following are significant: (1) a higher incidence of bacteremia and (2) the presence of other diseases. While the peak incidence of pneumonia is often found to be from 20 to 50 years, in our cases at the Boston City Hospital it is from 30 to 60 years. Whenever the incidence of pneumonia is higher in individuals over 40 years than under 40, both the bacteremic incidence and the fatality rate will be higher. In order to compare fatality rates in different clinics, it is necessary to compare both the ages and the bacteremic rates. For example, Table 3 is instructive.

This table shows that the highest fatality rate occurred in the clinic with the highest bacteremic rate, and the greatest number of patients over 40 years of age, and the lowest fatality rate was reported from the clinic with the lowest incidence of bacteremic cases and the highest percentage of cases under 40 years of age. This table seems to emphasize the importance of taking into account both the bacteremic incidence and the age distribution of any large group of cases, when fatality rates and results of treatment are compared.

Type of Pneumococcus.—The type of infecting pneumococcus has long been regarded as important in affecting the outcome of the disease, and its significance cannot be ignored. Part of the variations in the severity of the disease produced by different

TABLE 4.—*Results of Serum Treatment at Boston City Hospital**

	Fatality Rates in Different Types Per Cent					
	I	II	III	V	VII	VIII
Bacteremic: No serum	70	(76)† 86	94	79	88	
Bacteremic: Serum	25	(44) 35	81	21	38	
Nonbacteremic: No serum	25	(20) 11	38	15	16	
Nonbacteremic: Serum	8	(10) 8	24	4	5	
All cases: No serum	44	(42) 36	47	38	29	25
All cases: Serum	19	(24) 19	43‡	8§	12¶	10
Per cent of total cases showing bacteremia	35	45	23	43	20	

* These results have been summarized from the papers of Finland and his associates at the Boston City Hospital (16, 17, 18).
† Figures in parenthesis indicate fatality rates in a ten-year period.
‡ Results of 1 year—1937-1938.
§ Results of 3 years—1935-1938.
¶ Results of 5 years—1933-1938.

types of pneumococci would seem to be dependent upon the age at which the patient is infected with a particular type of pneumococus, and the variation in the capacity of the organism to invade the circulating blood. Of the common types, the fatality rate is highest in order of frequency in Types III, II, V, I, VIII, and VII. This corresponds roughly with the bacteremic incidence with all types excepting Type III. It has been maintained that one of the reasons why Type III is so serious a disease is that it occurs predominately in elderly people. This is true in part, but from the experience of Finland and Sutliff,[13] the fatality rate in Type III pneumonia has always been higher than with any other type, regardless of the age of the patient and the incidence of bacteremia. The next most serious type is Type II, since it is accompanied by a high fatality rate, especially in patients over 40 years of age.

In summary, then, it can be said that the type of infecting pneumococcus is significant in prognosis, in particular Types II, V, and III, and this is so even when the incidence of bacteremia and age are considered.

Number of Lobes.—The number of lobes involved indicate the severity and extent of the infections, so that the fatality rate rises with the increase in the number of lobes involved.

Pregnancy.—Finland and Dublin[14] have shown recently that pneumonia occurring in the pregnant woman has about twice the fatality rate of the same disease in the nonpregnant woman.

Leukocyte Count.—The leukocyte count in itself may not be of aid in prognosis; but, speaking broadly, it can be said that patients with leukopenia have a higher fatality rate than individuals with a moderate leukocytosis.

Alcoholism.—Individuals who use large amounts of alcohol have a higher risk rate than those using moderate amounts, or the teetotalers. On this point there is general agreement.

Race and Type of Work.—These two factors are operative and are especially significant in the case of the colored race and of the person whose occupation is that of heavy manual labor. That is to say, the colored man and the laborer have a poorer chance of recovery than the white individual who is not a laboring person.

Focal and Mixed Infections.—Individuals with focal infections, such as empyema, and infections due to more than one type of pneumococcus or another organism have a higher fatality rate than those with a single infection or without a complicating focal infection.

Debilitating Diseases.—When patients with cardiovascular, renal, or hepatic disease develop pneumonia, it is always a serious matter. Cohn and Lewis[15] have demonstrated the fact that the fatality rate is always higher regardless of age.

To sum up, then, it is evident that the following factors may be considered unfavorable in assessing prognosis in pneumonia: Age over 40 years, bacteremia, infection with Types II, V, or III, involvement of multiple lobes, type of work, overindulgence in alcohol, cardiovascular disease, and the presence of focal infections. The more "untoward" factors that are present, the more serious the disease and the poorer the outlook. To repeat, then, the most important are the age and the incidence of bacteremia.

SERUM TREATMENT IN PNEUMONIA

No discussion of sulfapyridin treatment of pneumonia would be complete without the inclusion of some statement concerning the value of specific serum treatment, so that one may have some basis for comparing results. As more and more experience has accumulated over the past twenty-five years, we are now in a position to say something about the treatment of some types of pneumonia with specific sera. This is especially true of Type I, but information is now available for a statement concerning Types II, V, VII, and VIII, as well.

The following statements concerning the value of Type I antipneumococcic serum are justified. It reduces the fatality rate, shortens the course of the disease, prevents a spread of the infection, and greatly reduces the incidence of empyema and other

focal infections. In order to obtain the best results it is necessary to treat the patients early, that is, before the fourth day of the disease; and to use large amounts of potent serum which will produce either no reaction or, at best, only minimal thermal reactions. When patients are treated with specific serum after the fourth day of the illness, or with serums of low potency, then the results will be poorer, especially when the serum causes reactions and is not given in adequate amounts.

The most striking results are obtained in patients under 40 years of age, without bacteremia and with only a single lobe involved, who are treated before the fourth day of their illness. The fatality rate can be reduced at least 66 per cent in all nonbacteremic cases, and at least 50 per cent of the bacteremic cases with the proper use of serum. In certain groups of cases the fatality rate can be reduced to between 1 and 3 per cent with the use of Type I serum.

In Type II cases, the results of serum treatment have varied in different clinics, and from one year to another. This has been found to be due to the use of varying amounts of serum and to the lack of serum of uniformly high potency. Moreover, it is known that the fatality rate of Type II infections is often very high, and that this organism tends to invade the blood much more often than do other types of pneumococci. Within recent years it has been possible, by using potent rabbit and horse serums in large amounts, to reduce that fatality rate in patients with Type II pneumonia. Here again, the best results are obtained in nonbacteremic patients under 40 years of age, with a single lobe, who are treated before the fourth day of their illness. Less striking results are obtained in patients over 40 years of age, especially when there is bacteremia.

What has been said for Types I and II also applies to Types V, VII, and VIII. The results of serum treatment of other types are too limited to say just what their effect will be in the future, although the results so far indicate that they can be influenced in a favorable sense.

Table 4 summarizes some of the results of serum treatment at the Boston City Hospital, as compiled by Finland and his associates.

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URINARY TRACT INFECTIONS IN THE NEWBORN*

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DISCUSSION *by Elmer Belt, M. D., Los Angeles; Phillip E. Rothman, M. D., Los Angeles.*

ALTHOUGH the subject of urinary tract infections in children has been exhaustively reviewed in pediatric literature, similar infections occurring in newborns have received scant attention. Various authors[1-12] have reported small series of cases (Table 1); and these reports may be briefly summarized as follows: the occurrence of urinary tract infections ("pyelitis") in the newborn is not rare. The symptoms may appear a few hours or a few days after birth. There is always fever, but this may not be high. Gastro-intestinal symptoms are most always present, but symptoms referable to the urinary tract are usually absent. The higher percentage of cases occur in males (see Table 1). Hematogenous infection (septicemia) is suspected, but not proved. The prognosis is good, most of the patients recovering with routine medical care. There were, however, five deaths in the above reported series. Runge's[5] case showed, at autopsy, severe bilateral pyelonephritis, with small abscesses in the kidneys and dilatation of the pelves and ureters with cystitis. One of Sauer's[8] patients died at the age of seven weeks and showed congenital stenosis of the right ureter with multiple abscesses of the right kidney.

REPORTS IN THE LITERATURE

It is striking that, in reviewing the reported series, no emphasis was placed on the importance of congenital obstructive lesions as etiologic factors in the neonatal pyurias, and none of the authors recorded urinary tract studies (pyelography) in an attempt to discover the presence or absence of such obstructive lesions. The recovered patients were followed over very brief periods of time, usually a few days. It is entirely probable that in many of these cases the pyuria recurred later in life, and that obstructive lesions with subsequent hydronephrosis and hydro-ureters with chronic recurring pyuria occurred and were overlooked.

INCIDENCE

Urinary tract infections in the newborn are undoubtedly far more frequent than the reported cases would lead one to believe. Campbell[12] states that, of 961 infants and children admitted to the hospital with urinary infections, fifty-seven, or 6 per cent, were under three months of age, and of these eighteen were classed as "chronic." Un-

* Read before the Pediatric Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9–12, 1938.

TABLE 1.—*Urinary Tract Infections in Children. Summary of Reports in the Literature.*

Author	Year	No. Cases	Males	Females	Age at Onset Days	Result
Kavalesky and Moro [1]	1901	2				One died, eleventh day, B. coli septicemia.
Smith [2]	1918	2	Not stated		2 to 14	Recovery.
Helmholz [3]	1918	3	3		2 to 10	Recovery.
Hornung [4]	1921	1		1	3	Died later of diphtheria.
Runge [5]	1923	1	1		10	Died age twenty days bilateral pyelonephritis with abscesses. Marked bilateral dilatation of both pelves and ureters.
Finklestein [6]	1924	3		3	2 to 3	Recovery.
Graham [7]	1925	6	3	3	12 hours to 3 days	Five recovery. One death fourth day, no autopsy.
Sauer [8]	1925	12	11	1	6 to 28	Ten recovered. Two died—one aged two weeks. Congenital stenosis right ureter, multiple abscesses of right kidney.
Conrad [9]	1926	3		3	1 to 3	Recovery.
Patterson [10]	1931	2	2		29 to 31	Recovery.
Litchfield and Gillman [11]	1932	1	1		3	Recovery.

doubtedly, many cases have been reported in series dealing with pyelitis in general. Bigler[13] states that, in eighty-five children with anomalies of the urinary tract, the lesion was congenital in sixty-nine; thirty-two of the eighty-five had pyuria, and pyuria was present in half of the fifty-two cases with obstruction. Bigler[14] also reviewed the subject of congenital anomalies of the urinary tract. Their frequency is indicated by the fact that in a series of 153 consecutive necropsies on children covering a period of eleven months, anomalies of the urinary tract were present in 13 per cent, and all of these could be explained on a congenital basis. Campbell[12] states that urinary infection in the newborn is not uncommon, but is seldom recognized because of failure to consider it in the differential diagnosis and failure to examine the urine. He further states that many cases seen at several weeks or months of age undoubtedly began in the first few days of life, but the condition was not recognized.

CASES UNDER OBSERVATION

It has been my privilege in the past ten years to observe three cases of pyuria occurring in the first few days of life. All of these cases received careful cystoscopic studies. One, a female, showed congenital stenosis with dilatation of one ureter. This child was observed over a period of ten years. The third, a boy, had a congenital median-bar obstruction of the neck of the bladder which was treated surgically. This infant is well at the age of twelve months. The protocols of these cases follow:

REPORT OF CASES

CASE 1.—Female, born on July 5, 1928. The birth weight was seven pounds five ounces. The patient was the second child and was normal at birth. On the second day the temperature was 100 degrees rectal, and on the tenth day 102 degrees rectal, reaching 105 degrees rectal on the sixteenth day. On the sixth day the baby developed vomiting, with listlessness and failure to take food. Catheterized urine was obtained on the eleventh day and showed numerous pus cells and, on culture, B. coli. The blood count on the eleventh day was as follows: Hemoglobin, 94 per cent; red blood cells, 5,576,000; white blood cells, 17,600; polymorphonuclears, 58.5 per cent; lymphocytes, 40.5 per cent; monocytes, 1 per cent. Three examinations of the urine showed pus. Cystoscopy was done on July 18, 1928, the thirteenth day, by Dr. Elmer Belt. This showed extensive cystitis. The right ureter was readily catheterized with a No. 5 whistle-tip catheter, but an olivary-tip catheter reinforced with wire was necessary to penetrate the left ureteral orifice. The catheter, after passing this point, readily passed to the renal pelvis, and a rapid flow of thick urine was obtained. The urine from bladder and both kidneys showed pus cells and Gram-negative bacilli which, on culture, was B. coli. Pyelograms: The left pelvis filled only partially, but suggested a dilated renal pelvis. The right was normal. On the fifteenth day the baby was toxic with high temperature and poor color, and was transfused 105 cubic centimeters of whole blood. Following this the baby improved, but the temperature continued. A second cystoscopy was performed on August 2, 1928, at the age of twenty-eight days. The bladder was inflamed, but not covered with fibrous exudate as formerly. Both ureteral orifices were readily seen. The right was catheterized with a No. 4 ureteral catheter and gently lavaged with one-half per cent silver nitrate. An attempt was made to catheterize the left ureter, but this could not be passed more than one-half centimeter. On August 7, 1928, a third cystoscopy was done. A No. 4 catheter was inserted 7 centimeters up the left ureter and a scant flow of cloudy urine was obtained. The baby's general condition improved and the temperature subsided. She was discharged on August 11, 1928, at the age of one month and six days, weighing seven pounds twelve ounces. Subsequent cystoscopic examination was done on August 14, 1928, which showed improvement, and the left ureter could be passed without difficulty. The baby has been seen at frequent intervals from this time, having been last examined on January 22, 1938, with no recurrence of the pyuria over a period of ten years.

* * *

CASE 2.—Female, first pregnancy, born on November 22, 1928. The birth weight was eight pounds ten ounces. The patient was seen on day of birth, at which time there was noted cyanosis with jerky, rapid respirations without signs of trachial obstruction. An x-ray of the chest showed a broad thymus shadow, with the heart normal and the lungs expanded. X-ray treatment was given the same day. The baby's color improved, she appeared normal the following day and remained so until December 3, 1928, at the age of eleven days, when she developed a temperature of 103 degrees rectal. There were no physical findings of importance. The urine, December 5, 1928, showed a heavy trace

of albumen and numerous pus cells, and on culture showed B. coli. Blood count on December 5, 1928: Hemoglobin, 106 per cent; red blood count, 5,750,000; white blood count, 14,800; of which polymorphonuclears, 57 per cent; lymphocytes, 39.5 per cent; monocytes, 3.5 per cent. The baby continued to run fever. A cystoscopic examination was done by Dr. Elmer Belt on December 15, 1928. The bladder was reported deep red in color and covered with a general sprinkling of flaky pus. The ureteral orifices were edematous, but were readily entered. Catheters were passed to 10 centimeters on each side, when a small flow of urine occurred and specimens were obtained from each side. No pyelogram was made. Cultures from the left kidney and bladder urine grew B. coli. The right kidney culture was sterile. Subsequent cystoscopic examinations showed a general clearing of the infection without hydronephrosis. The last examination was made on May 9, 1929. The baby has not been seen since February 18, 1930. At that time the urine was normal, and she is reported to be in good health at the present time.

* * *

CASE 3.—Male infant, born on April 27, 1937; third pregnancy; the first two (males) having been normal. The mother had pyelitis during both former pregnancies, but not with this one. The birth weight was nine pounds one ounce. The baby was normal at birth, but on the fourth day developed temperature 103 degrees rectal, and ran a fever from the fourth to the tenth day, reaching 104 degrees rectal. The patient was seen by me on May 5, 1937, at the age of eight days. The baby was restless and feverish, and diarrhea was present. The throat and ear drums were slightly red. Blood count on May 7, 1937: Hemoglobin, 124 per cent; red blood count, 6,750,000; white blood count, 19,300; polymorphonuclears, 70.5 per cent; eosinophils, 6 per cent; lymphocytes, 8.5 per cent; monocytes, 14.5 per cent. The voided urine showed albumin and innumerable pus cells; no red cells or casts. The catheterized urine showed B. coli. The baby became toxic and dehydrated(and on May 11, 1927, an intravenous drip was started with five per cent glucose, to be discontinued on May 13, 1937. The white count rose to 34,000, with 65 per cent polymorphonuclears. Elixir mandelate was given, one-third teaspoon three times daily; but this was discontinued on account of vomiting. The blood nonprotein nitrogen on May 12, 1937, was 58 milligrams per cent. A cystoscopic examination was done by Dr. Elmer Belt on May 20, 1937. The bladder mucosa was very red and injected. Both ureters were readily entered, and pyelograms showed a beginning dilatation of both pelves and ureters. The baby improved and the temperature became normal. He was discharged from the hospital on May 23, 1937. On June 3, 1937, he weighed ten pounds four ounces and was in good condition, but the urine contained pus. Sulfanilamide was given, beginning on June 18, 1937, five grains daily for three days, and two and one-half grains daily for three days. The urine cleared and contained no pus or bacteria. On July 29, 1937, the baby appeared fretful, and examination of the urine again showed pus and bacteria. Sulfanilamide was repeated as before, and the pus disappeared from the urine. A cystoscopic examination was again performed by Dr. Elmer Belt on October 4, 1937. Examination at this time showed a definite congenital median-bar obstruction of the neck of the bladder. Ten days later a deep incision was made through this bar at the bladder neck with a high frequency knife, without hemorrhage. The baby suffered no ill effects from this operation, and the urine has been normal since this time. The baby was last seen on April 15, 1938, age one year. He was normal in every respect. The urine was negative.*

COMMENT

Such a small series of cases permits of no conclusions. It is entirely possible that the next three cases may fail to show congenital obstructive lesions. It would seem obvious, however, that such lesions should be searched for. The dangers incident to retrograde pyelography in the newborn are negligible if done by a skilled operator. The dangers of subsequent damage to the kidneys and urinary tract secondary to chronic obstruction, plus recurring or chronic infection, are very great. Many of the cases of hydronephrosis with hydroureters seen in infants and children date their symptoms from birth or very early infancy. Treatment in these advanced cases is usually futile even in skilled hands. Prevention of the damage by early recognition of the condition and relief of the obstruction before permanent and irreparable damage has been done, is the duty of the pediatrician following the case.

Many pediatricians, for some reason, are opposed to urologic studies in young infants. They allow infants to go through successive attacks of pyuria, each one "successfully" treated by medical therapy. This may be methenamin, alkaline therapy, ketogenic diet, mandelic acid or sulfanilamide, etc. The danger from such treatment in cases having organic congenital obstruction consists in the temporary abatement of the pyuria and in the masking of the underlying obstruction. In Case 3, cited above, the urine cleared on three successive times after administration of sulfanilamide, and could have been reported as a medical cure had it not been for the follow-up. Not all cases of pyuria in infancy are secondary to congenital obstruction, and in not all cases is urologic study indicated. Obstructive lesions may be suspected in cases of pyuria occurring in the newborn period, in males at any age, and in recurring pyuria at any age in either sex. It is only by keeping this in mind and by following infants showing urinary tract infections over a considerable period after medical "cures," that the congenital obstructive lesions may be discovered.

IN CONCLUSION

1. Three cases of pyuria occurring in the newborn period are reported. Two were females, one male.

2. Two of these three cases on urologic study showed congenital obstructive lesions. Treatment by removing the obstruction resulted in the patients' recovery.

3. Pyelography and cystoscopy can be safely performed in newborn infants.

4. Treatment by medical means may result in temporary abatement of the pyuria and masking of the underlying congenital obstruction.

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DISCUSSION

ELMER BELT, M.D. (1893 Wilshire Boulevard, Los Angeles).—If one looks upon the urinary tract purely as a problem in plumbing, Doctor Happ has shown the necessity of revealing possible defects in the mechanism of transmission of the urine through it, defects which cannot be helped by drugs. The normally narrow areas at the ureteropelvic juncture and at the ureterovesical juncture may be further constricted by anomalies, scar or edema. Even in tiny babies the means is at hand of discovering these defects. Instruments are now available with which the urinary tract of the smallest baby may be visualized. Where the secretory power is still strong, diodrast may be injected subcutaneously and will reveal the infant urinary tract just as clearly as it does in the adult. When mechanical obstructions are found, the ureteral catheter can be used as an efficient means of relief and correction of the defect.

Again, due to his power of close observation, Doctor Happ has brought us a group of cases of a kind very rarely seen. There is nothing about the infant mechanism which would protect it from pyelitis. The factors which bring about this condition later in life must operate here with equal frequency. Indeed obstructive anomalies in the urinary tract should be apparent early in life, if we but have eyes to see their signs.

Doctor Happ has clearly outlined the method of combating urinary infection in these tiny patients. The mechanics of edema due to inflammation, narrowing further the normally narrow places in the tract, plus further obstruction from clogging due to particulate matter by epithelium, pus and bacterial bodies settling into these funnel-like narrowings, are dealt with concisely. There is no fundamental difference in type between the treatment afforded the babe and the adult. Fluids are forced to thin down the urinary stream, making less possible clogging from débris. Alkalies help relieve edema. Various urinary antiseptics are used. Mandelic acid and ammonium chlorid, when they are tolerated and when the kidney function is good enough to secrete them, are singularly effective in the colon group of organisms, and possibly the only antiseptic substance capable of destroying the bacillus fecalis. Sulfanilamide, the exceptionally ubiquitous urinary antiseptic, is effective wherever the plasma flows. It seems to strike both sides of the secreting mechanism, acting through the urine and through the plasma. It is effective even where the secretory power is poor, and ineffective only in combating streptococcus fecalis and streptococcus viridans. However, it is but weakly effective against the staphylococcus albus.

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PHILLIP E. ROTHMAN, M.D. (3875 Wilshire Boulevard, Los Angeles).—Pyuria in infancy has always created clinical interest because of our lack of knowledge relative to the mode of infection and the character of the lesion. This is due to the paucity of pathological observations. Accordingly, greater advances have been made in diagnosis and treatment. The younger the patient, the more likelihood that an abnormality of the urinary tract exists, and this is particularly true in the newly born. Gastrointestinal symptoms, with vomiting and signs of pylorospasm, are common manifestations. Marked pallor without anemia is often observed. Sudden dehydration, without apparent explanation, is an alarming complication. The successful treatment by a skilled urologist is an impressive technical achievement that would have appeared almost incredible to the first generation of pediatricians.

Doctor Happ has emphasized what undoubtedly remains the most important phase of the entire subject, namely, the danger of permanent renal damage in cases that remain imperfectly treated. Medication may so completely mask the picture that the patient appears in excellent health, afebrile and asymptomatic, during the period of kidney destruction. The renal parenchyma may be destroyed either from compression in the presence of an organic obstruction, or as the result of infection. It is this latter group that may produce, after a lapse of years, the picture of chronic nephritis. The insidiousness of its development should be a constant warning to repeat urine examinations of all patients who have had a previous attack of pyuria, and, if infection persists, to demand a urologic study.

THE LURE OF MEDICAL HISTORY†

THE MICROPHONE, STETHOSCOPE, TELEPHONE, AND ARTIFICIAL AIDS TO HEARING

THEIR HISTORICAL RELATIONSHIP

By G. R. OWEN, M.D.
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A CERTAIN local otologist, who has done much experimental work with the audiometer, ascribed the first use of the word "microphone" to Bell and his contemporaries; and in its practical consideration he was correct. He was interested to know of its use two and one-quarter centuries ago, and asked that we write him in detail, which we did much as follows:

I have devised an instrument suitable for magnifying weak sounds which is called a microphone; the microphone in its present form consists simply of a lozenge-shaped piece of gas-carbon one inch long. . . .

Thus, David Edward Hughes, the English-American inventor, in 1878, to whom is credited the first use of the word, defines it. (The use of the carbon element is credited to Bell with a two-year priority.)

The telephone seems to have been born twin to the carbon microphone, so a brief interpolation as to its history may not be amiss. Dr. W. A. Dewey, a globe trotter with a penchant for the acquisition of scientific curiosa, writes me as follows:

There is a fine tablet displayed on the post-office in Florence which reads, "Antonio Meucci, inventore del telephone, mori 1889 in paese straniero povero e defraudata de suoi diretti." Professor Passani assured the writer personally that this statement is correct. The Minister of Finance in France in 1890 conceded that M. Charles Étienne Bourseul really invented the telephone in 1854, for which he received the Legion d'Honneur. . . . The writer recalls being shown in Vienna some forty years ago, in an old German encyclopedia, a cut of an apparatus describing a "fern-sprecher" that dated a century or more ago. The old Herr Professor who produced this evidence did so to dispute my boastful claims that it was an American who invented the telephone.

The mammoth Oxford dictionary traces the word back to the "Philosophical Transactions," 1727, thus:

Microphones or miraculous sticks . . . that is, magnifying ear instruments.

† A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

We have been unable to find the word in any dictionary prior to 1706, where Phillips defines it:

Microcousticks or microphones; instruments contrived to magnify small sounds, as microscopes do small objects.

One concludes that this new word was without great interest or significance, for even Johnson ignores it in his sixth edition, and it does not appear again until 1827, when Sir Charles Wheatstone, the English physicist, claimed paternity.

Three instruments for the magnification of sound were submitted to the Royal Society between 1665-1681. One wonders if there is some connection between "microcousticks" and "miraculous sticks"; a sort of corruption of a Hellenism into the vernacular, or were the devices submitted of a stick form. The latter, probably, for we recall that René Laennec, the inventor of the stethoscope (1819), when confronted with a very obese female patient, and finding the ear-to-skin method neither esthetic nor adequate, said: "I happened to recall a simple and well-known fact in acoustics and fancied it might be turned to some use on this occasion. The fact I allude to is the distinctness with which we hear the scratch of a pin on one end of a piece of wood on applying our ear to the other."

It is a far cry from the ubiquitous broadcasting "mike" which alternately titillates and torments us, to the primitive stethoscope; yet the definition, "instruments contrived to magnify sound," of 225 years ago, is as aptly applicable to the latter as to the former. They were, indeed, classified and indexed under "Artificial Aids to Hearing," by the Royal Society of the seventeenth century.

That irritable, disputatious, versatile and scientifically admirable Robert Hooke (1635-1702), Curator of the Royal Society, has given us a very definite picture of the possibilities of sound transmission and magnification by means of his otocousticons, two of the three "artificial aids" previously mentioned; a son of that century, acclaimed as the century of the birth of experimental science wherein we may contrast such an absurdity as Digby's "Sympathetic Powder" with William Harvey's revolutionary "De Motu Cordis." We find Harvey following Willis in the famous case of Lady Conway only to be supplanted by Greatrakes, the notorious Irish Stroker, a magnificent quack. It was the age of Kepler, Newton, and Galileo, yet we know that in the realm of physics it was forbidden to deviate from the principles of Aristotle, and this prevailed one hundred years after the experiments of Galileo, who had been forced to renounce many of his contradictions as heresies. The Parisian universities were adamant, and "Stubbeites" in England bellicose. Into this era of credulity and bigotry was born the great Royal Society at old Gresham, with its Harveian doctrine of "observation, hypothesis, deduction and experiment."

Exhaustive experimental studies were made of sound and acoustics in that century, and it would be strange indeed if much attention had not been given to the transmission of sound over long distances, a crying need centuries before Alexander had summoned his troops by means of enormous horns of bronze. And so there was, and the consideration of the history of telephonics injects itself into our potpourri title. Hark to Hooke!

'Tis not impossible to hear a whisper a furlongs distance, it having been already done; and perhaps the nature of the thing would not make it more impossible, though the furlong should be ten times multiply'd. It has not been yet thoroughly examin'd, how far the Otocousticons may be improv'd, nor what other ways there may be of quickening our hearing, or conveying sound through other bodies than the Air: for that is not the only medium, I can assure the Reader, that I have by help of a distended wire, propogated the sound to a very considerable distance in an instant, or with as seemingly as quick a motion as that of light, at least, incomparably swifter than that, which was at the same time propogated through the Air; and this not only in a straight line, or direct, but in one bended in many angles.

The earliest practical application of sound magnification appliances to the aid of the deaf is found in the "Phonurgia Nova" of Athanasius Kirscher, the Jesuit, published in 1673, which described many modifications of an elliptical double-ended tube, one of which Banzer had used in 1640, and to which he had added a diaphragm of pig's bladder on the receptor end; very possibly the inspiration of the "artificial tympanum" of Hooke's otocousticon. These primitive conceptions, as well as the equally primitive trumpet, have persisted in many of our present forms. Magnetism was the only electrical modality known in his day, so as Halsey Fredericks of the Bell Laboratories states, electrical amplification could not have been a factor. Hence, Hooke's devices could have made no radical departure from the then accepted forms. The "miraculous stick" used by Laennec had long been adapted to both air and bone conduction, though not as a stethoscope. An early and interesting form of the bone-conduction type was the double-end tube—an end each for the teeth of the speaker and the listener, much as the famous Paladino rod transmits from the larynx of the speaker to the cranial bones of the subject. This principle exists today in the Japanese otocoustic fan, which utilizes a dental contact.

The length of a chord required to the pitch; the laws of vibrating chords and the velocity of sound were known to the Royal Society, and in all of this Hooke was interested. Pepys, himself an excellent musician, relates that a discourse of Hooke's on musical notes was excellent, but, he records, "to tell how many strokes a fly makes with her wings is a little too much refined." Pepys was incredulous, but he possessed the discernment necessary to rate the insignificant-appearing Hooke over that wealthy, aristocratic, and excellent scientist, Robert Boyle.

The following quotation from Hooke is disturbing to our twentieth century smugness. A dreamer of dreams and a doer of deeds, Hooke with his microphones invaded a field in which he was but a dilettante. By no means can we give him priority in the invention and use of the stethoscope, for his concluding sentence in the following quotation is a disclaimer; but by 150 years we can grant him priority over Laennec in everything but the urge of pursuit born of Laennec's medical training and environment:

There may also be a possibility of discovering the Internal Motions and Actions of Bodies by the sound they make, who know but that as in a Watch we may hear the beating of the Balance, who knows I say, but that it may be possible . . . that one may discover the Works performed in the several Offices and Shops of a Man's Body, and thereby discover what Instrument or Engine is out of order, what Works are going on at several times and lie still at others, and the like. . . . I could proceed further, but methinks I can hardly forbear to blush, when I consider how the most part of men will look upon this. . . . And somewhat more of Incouragement I have also from Experience that I have been able to hear very plainly the beating of a Man's Heart, . . . the stopping of the Lungs is easily discovered by the Wheezing . . . for to me these Motions and the other seem only to differ secundum magis et minus, and so to their becoming sensible, they require that their motion be increased, or that the Organ (the examiner's ear) be made more nice and powerful to sensate and distinguish them, many cases *there may be Helps found, some of which I may, as opportunity is offered, make Trials of, which, if successful and useful I shall not conceal.*

1800 West Sixth Street.

JOHN TOWNSEND—THE PERIPATETIC PIONEER*

By FRANCES TOMLINSON GARDNER
San Francisco

PART I

ALTHOUGH they followed a calling whose usual habitat is a single restricted locality, the medical men of the '40's and '50's were no more immune to the call of adventure than men of any other profession. As the long lines of emigrant wagons spread across the great plains, and the white sails and puffing stacks of ships left eastern harbors bound for California, most companies contained one or more disciples of Aesculapius. These physicians were adventurers fundamentally and no call of duty, love or money was as strong as the siren song of the unknown. In the early days of California, even before the rush for gold became the goal, such a number of doctors appeared within her boundaries that she was overpopulated with them, and many turned to other things to make a living. They were jacks of all trades, and some of the occupations in which they expended their excess energies were hard to justify by the oath of Hippocrates. They became merchants, miners, soldiers, editors, and farmers, and at least one became a swindler. They sought and found their levels as inevitably as though they had never left their native states.

DR. JOHN TOWNSEND

A pioneer of pioneers, a perpetual seeker after the foot of the rainbow, was Dr. John Townsend, a member of the first party ever to bring wagons into California.

John Townsend was born in Fayette County, Pennsylvania. The date of his birth seems uncertain, but can be placed reasonably within the first ten years of the nineteenth century. His father was an Englishman, a pioneer of Fayette County, who brought up little John on bed-time stories of exciting pioneering in uninhabited Pennsylvania.

JOHN TOWNSEND

Early in his life the boy showed passionate interest in the feats and struggles of inhabitants of an outpost.

Townsend had the average American education of his day and took his degree from Lexington Medical College. No more had the ink on his diploma dried than he began to show the spirit of curiosity and the inability to stay put which characterized him all his life. Gradually he wandered farther and farther West, as though drawn by an invisible magnet. Although he had never heard of California in more than a casual way, it was as if he could not resist the sound of the waves on the shore of the Pacific Coast. After a year or two of practice in Pennsylvania, now too bucolic by far, he turned up in Ohio where he was married, in Stark County in 1832, to Elizabeth Louise Schallenberger. Finally, in 1843, he was obstetrician, surgeon and general practitioner in Buchanan County, Missouri, having made a brief stop in Indiana en route. As he rode about on his rounds he heard the county people speaking more and more about this wonderful new land beyond the Rocky Mountains. It was Mexican, to be sure, but reputed to be bounteously supplied with all the good things of the earth. It was fertile, it was delightfully warm in winter and cool in summer, and it was practically unpopulated except for some notoriously lethargic Spanish folk and a lot of very lazy Indians. The consensus of Missourian opinion was that a man would have an unexampled opportunity there if he were willing to apply himself—and if he were willing to make the laborious trip necessary to reach the promised land.

Townsend was anything but hard to persuade. He had put down no roots to speak of since gradu-

*From the University of California Medical School Library and the California State Medical Library.

ation from the medical school. He had, besides, another great inducement in the Californian climate; for Elizabeth, his wife, had never been strong and in recent months had been in very fragile health. When Elisha Stevens organized his party in 1844, the section of it which was bound for California contained the bright new wagons and equipment of John Townsend, his wife and his brother-in-law, Moses Schallenberger, a boy of seventeen.

STEVENS-MURPHY PARTY

The Stevens party has often been called the Murphy party or the Stevens-Murphy party, although it was actually organized by, and was under the orders of Elisha Stevens. The reason for this constant confusion lies in the fact that there was a very large number of persons named Murphy in the train. It was made up of sections for California and Oregon. The sections traveled as one train as far as Fort Hall, where approximately half the party turned off on the Oregon route, while the California group, which contained eleven wagons, twenty-six men, eight women and a dozen children, continued down the Mary River (now the Humboldt) until they reached its sink.

The Stevens party was the second wagon train to start the trip across the prairies in 1844, and its path was badly marked and long. Traffic had not yet worn wheel marks in the earth of the plains, and an occasional scout or trapper was all that could be counted on for guidance after civilization was left behind. By the time the California wagons reached the Humboldt's sink, though the season was growing late, they were forced to stop and spend ten days to give the oxen strength to carry them over the last, but most taxing weeks of the journey.

The party left the Humboldt behind early in November, and looked ahead to see the formidable Sierra purple and frowning in the distance. Their passage to the base of the mountains was a long agony, for the hoofs of the oxen grew soft and sore from wading in the icy streams, and the grass was poor and thin in the late season.

THE TRUCKEE COUNTRY

Late in November they crossed the Truckee and the Bear rivers, under the guidance of an Indian whom they named Truckee and for whom they named the river and lake. They were, it appears, the first emigrant party to take this route, now the route of the railroad. At the forks of the Truckee, Mrs. Townsend, Ellen Murphy, John and Daniel Murphy, and a man named Magnent left the party and swung downstream to Lake Tahoe, through to St. Clair's rancho and so to Sutter's Fort. They arrived safely with all their horses, though they had a hard and hungry journey.

The rest of the party went on to Truckee Lake at the very foot of the pass in the Sierra. This lake, sparkling in the late autumn sun, was within a short time to become a place of tragedy and ill omen, for two years later it earned its share of the greatest debacle in the history of the emigration, taking the name by which it is known today, Donner Lake.

At the western end of the lake, under the shadow of the terrible perpendicular pass, the party drew a long but apprehensive breath. While they had rested at the Humboldt, snow had begun to fall in the mountains; and though they made their best time, they had been compelled to spend a long month of desperate haste and agony to reach the spot in which they were now camped. As they looked up at the forbidding silent pass, powdered with the first light snow, they confirmed the unspoken apprehension that it was too late for a concerted crossing of the mountains.

SIERRA HARDSHIPS

It is difficult for the modern eye, especially an eye unaccustomed to the frozen dangers of the Sierra, to picture the happenings of the next few weeks. It is hard to appreciate that the trip, for which three hours is now considered a long time, consumed weeks of heart-breaking and terrifying struggle. Few realize that the disaster of the crossing was not in its first upward climb from the east, sheer and terrible though it was, but in the endless miles of descent into the valley. This was the Via Dolorosa of the emigrants, who dallied too long and were caught in the mountains after winter had begun.

There was no time to be lost. Snow had begun to pile in small drifts around the camp, and the clouds gathered spitefully and ominously even as they talked. Without snow to hamper them, the animals, though in poor condition, might drag the wagons over the pass, but if the snow began to fall no man could help them over the boulders nor keep them on the surface of the soft deep snow on the plateau beyond.

(To be continued)

CLINICAL NOTES AND CASE REPORTS

HERPES ZOSTER AND VARICELLA IN PATIENT WITH CARCINOMA OF PLEURA AND LUNG*

By HARRY E. ALDERSON, M. D.
AND
PHILIP H. PIERSON, M. D.
San Francisco

THE subject of this report had been in the hospital for six months, with only occasional outside exposures. She developed herpes zoster, followed in nine days by typical varicella.

The possible close relationship of the virus of herpes zoster and that of varicella is indicated by the increasing number of similar case reports published the past few years.

REPORT OF CASE

CASE 1.—Miss A. E. (history No. 38859), aged 49, had an amputation of the left breast for carcinoma at Johns

* From the Clinics of Dermatology and Chest Diseases, respectively, Stanford University Medical School.

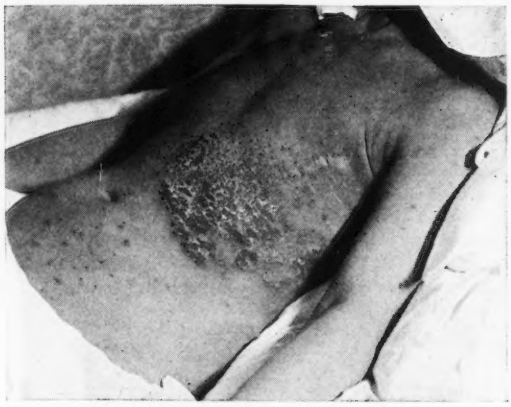

Fig. 1.—Varicella, accompanying severe herpes zoster in a case of carcinoma of lung and pleura.

Hopkins, by Doctor Kelly, in 1929. In 1938, carcinoma of the pleura and lung developed. At that time the patient was hospitalized under Doctor Pierson's care, receiving deep roentgen therapy by Dr. Eric Liljencrantz of Stanford University during August, 1938. After a long period of digestive disturbances, in September and October she began to improve, so that by February 8, 1939, she was able to eat well and take rather long walks without discomfort. On February 6, 1939, however, she developed severe herpes zoster in the distribution of the left ninth dorsal segment. The vesicles were almost hemorrhagic and confluent over an area from 5 to 10 centimeters wide. The pain was very severe.

On the ninth day of the herpes zoster typical *varicella* developed with widely scattered lesions, which appeared spread over the body, on the *scalp*, and *inside the mouth*. They developed in the usual manner, and in about two weeks had practically subsided.

The chest involvement in this case will be discussed in detail later in a special paper by Doctor Pierson.

490 Post Street.

TOOTHPICK IN THE SUBMAXILLARY DUCT AND GLAND

By H. P. Merrill, M. D.
Los Angeles

THIS patient, a healthy middle-aged male, was admitted to the Veterans' Administration Hospital, complaining of a discharging fistula on the left side of his neck. He stated that it had been present since the incision of an "abscess" several months before. This "abscess" had developed suddenly without any acute infection in the mouth or throat. Incision had relieved the immediate symptoms and the wound had closed in a few days, only to have the swelling recur, so that reincision had been necessary. This process had been repeated several times.

REPORT OF CASE

Examination showed a small fistula leading into the lower part of the submaxillary gland and discharging a small amount of purulent saliva. A probe passed well into the gland, but did not touch any hard substance. The gland was only slightly larger than normal. Within the mouth the distal part of the duct appeared normal, but back near the gland a tender mass was felt. After considerable search the orifice of the duct was located and a fine probe passed along the duct until a foreign body, assumed to be a stone, was located. The mouth and throat were clean. All teeth had been extracted for several years.

After two attempts by the resident to remove this foreign body intraorally had failed, I removed the gland and most of the duct. Prompt healing followed.

In the proximal part of the duct, and extending into the gland, was a piece of common wooden toothpick about three centimeters long. There was no calculus and no evidence of calcareous deposit on the toothpick. The gland showed practically no damage from infection, and would probably have returned to normal if the toothpick had been removed intraorally.

COMMENT

Strange foreign bodies have been reported in the salivary glands and ducts. Most of them seem to have been seeds or stems of plants or splinters. Many of them have been, like this one, so large that it seems impossible for them to enter a tiny opening that requires careful search to locate and enter with a fine probe.

The part foreign bodies play in the formation of calculi seems to me to be uncertain. I have not been able to demonstrate a definite foreign body nucleus in around forty calculi. Certainly, the dogmatic statement that all such calculi have a foreign body nucleus is not justified. This, as well as the statement about their rarity, has apparently been unquestioned since the condition was first described. Like bladder-stones they may or may not have a nucleus, and they are rare only because they are seldom looked for. Bimanual palpation of the gland and duct areas frequently shows up a more or less sensitive mass which probing or x-ray proves to be around a stone, in patients who have had no symptoms at all. Palpation and probing are of more value in diagnosis than the x-ray, as some stones and most vegetable matter do not show on the film.

All foreign bodies in the duct, and most of them in the gland, can be removed through the mouth. When an abscess or much acute inflammation is present, these should be treated before removal is attempted. Incision of the abscess is often followed by the appearance of the stone in the incision. Excision of the gland should be reserved for cases where the gland has been badly damaged by infection, recurrent stones, external incisions, or when malignancy is suspected.

458 South Spring Street.

Acidified Candy May Be Tooth Menace.—If acidified candy is frequently allowed to dissolve against the teeth, serious softening of the enamel may result, experiments summarized in *The Journal of the American Medical Association* suggest.

In the experiments of Edward S. West and Frederick R. Judy, freshly extracted teeth were mounted singly in rubber stoppers by embedding the roots in beeswax followed by a coat of acid-proof paint. Only sound enamel was exposed. The teeth were then exposed to solutions of varied strength of acidified candies in water, these solutions showing high acid reactions.

Although the action of the saliva in the mouth, where it is being continually secreted, is undoubtedly more efficient in combating the effects of acidified candies than in the experiments reported, the teeth treated in the experiments under conditions that led to dissolving of tooth enamel showed a chalky insoluble layer on the surface which could be easily scraped off.

The investigators are of the opinion that the dissolving of the calcium and phosphorus of the teeth by the acid in various foods may be an important factor in the general process of tooth destruction.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

URETERAL CALCULUS

I. SYMPTOMS

JAY J. CRANE, M.D. (1921 Wilshire Boulevard, Los Angeles).—The classical symptoms of pain, hematuria, pyuria and fever present during the passage of a ureteral calculus vary in intensity and duration, with the size and shape of the stone and the amount of obstruction produced. "The smaller the stone the worse the colic." Anuria and rupture of the ureter, while quite rare, are nevertheless serious and often deadly.

Pain: The calculus not acutely obstructing the outflow of urine, but causing slight back-pressure with dilatation of the pelvis or even a single calix, is usually of a dull, aching character, situated in the loin and costovertebral angle, radiating downward and forward toward the groin and external genitalia, with the maximum tenderness over the kidney pelvis or the outer border of the rectus on a level with the umbilicus. The pain is usually not constant, and varies in intensity, disappearing at times altogether, being interrupted by periods of calm during which time the fever usually also subsides, indicating improved drainage past the stone. Such a reflex or radiating pain, when occurring on the right side, associated with nausea and vomiting, may readily be mistaken for an attack of appendicitis.

With an increase of the distention of the urinary channels above the impacted calculus, caused by more complete stoppage of the passage of the urine, excruciating pain ensues. This severe type of pain (renal colic), is characterized by its waves of intense pain which are unendurable.

When the stoppage of urine is complete, the pain subsides and a more or less painless unilateral anuria results. Colic occurs early in the disease and tends later to become milder.

Hematuria: Microscopic blood is constantly found in the urine as long as the stone is harbored in the urinary passages, and is especially noted during the acute attacks. Gross blood may be present at times, but rarely in sufficient amounts to be considered serious.

Infection, which invariably ensues during the progress of the disease, is responsible for the chills and fever. Pyelonephritis, infected hydronephrosis, and pyonephrosis, due to calculus disease, are relieved promptly with ureteral catheter drainage or the sudden liberation of urine behind the stone. When drainage is restored, the fever subsides.

Anuria is characterized by little or no urinary output, and a rapidly progressing uremia with all of its manifestations, more rapid than otherwise because of the superimposed infection. Unless drainage is promptly instituted, death is certain.

Perforation of the ureter or pelvis results in an extravasation of urine, followed by cellulitis and infection. Sustained symptoms of sepsis, with localized pain and rigidity, are constant.

* * *

II. DIAGNOSIS

CHARLES PIERRE MATHÉ, M. D. (450 Sutter Street, San Francisco).—Although ureteral calculus can be accurately determined in 98 per cent of patients suffering from this painful disease, its diagnosis is not always simple. Its presence is still being overlooked as a considerable number of cases with stone in the right ureter have been previously operated upon for appendicitis (35 per cent) in our series. The attending physician is also likely to confuse ureteral stone with gall-bladder disease, tabes dorsalis, duodenal ulcer, inflammatory processes of the female adnexa and, in rare instances, with intestinal obstruction or pneumonia. It often simulates diseases of the upper urinary tract, caused by other types of ureteral obstruction such as ureteral stricture, ptosis of the kidney with kinking of the ureter, and extraneous pressure resulting from inflammatory lesions or neoplasms in the adjacent organs.

The symptoms are quite characteristic: they consist of pain in the form of renal colic, or continuous dull lumbar ache, and are usually accompanied by nausea, vomiting and gaseous distension of the abdomen, chills and fever, hematuria, frequency and dysuria. The previous passage of gravel or small stones should always lead one to suspect the presence of ureteral calculus.

The first step in ruling out appendicitis, gall-bladder disease or other confusing abdominal lesions, is the making of a careful urine analysis. A considerable number of patients present gross hematuria in whom the presence of blood in the urine is quite apparent. Careful microscopic examination of urine invariably shows erythrocytes which result from the scratching effect of the stone on the mucous membrane of the ureter. We encountered microscopic blood in all of the cases of ureteral stone that have come under our observation. Blood cells may also be found in the urine of the patient suffering from retrocecal appendicitis, but in these no stone-shadow is seen, the leucocyte count is higher, and the percentage of polynuclear leucocytes is elevated, etc. So, with careful study, the differential diagnosis between ureteral stone and retrocecal appendicitis can be accurately made. Albumin, leucocytes, and microörganisms are also found when concomitant infection is present. The presence of crystals is, again, of diagnostic value. These are usually of the variety which makes up the stone, and the finding of these crys-

tals in the patient suffering from uric acid stone which is nonopaque to the x-ray, is of great diagnostic value.

In making the diagnosis of ureteral stone, the information obtained from investigation of the ureter by means of the cystoscope, the passage of the ureteral catheter and the employment of the roentgen ray is invaluable. A certain percentage of stones situated in the lower portion of the ureter can be palpated by digital exploration through the rectum or vagina, and, in some instances, by careful palpation of the lower abdomen. The cystoscopic picture is quite characteristic of stone. When the stone is situated in the intramural portion of the ureter it can sometimes be seen projecting from the orifice; in others the ureteral orifice is swollen, edematous and bulging. In patients in whom the stone is situated higher up in the ureter, the orifice usually appears congested. In introducing the ureteral bougie, the sensation of resistance caused by the obstructing stone is of great diagnostic value. In passing the stone one often experiences a typical grating sensation. One may pass a wax-tipped catheter or bougie in order to obtain the characteristic gouge, the significance of which was emphasized by Howard Kelly some thirty-five years ago. The adoption of the water-dilating cystoscope has resulted in technical difficulties because the wax was often scratched in being introduced through the cystoscope; and thus erroneous conclusions have led many urologists to give up its use. The diagnostic signs of resistance and gouging of the wax-tipped catheter are valueless in patients presenting bifid ureter, diverticulum or greatly dilated ureter, because in these cases the catheter, in passing up the ureter, may fail to touch the stone.

The employment of the x-ray enables one to clear up the diagnosis in obscure, suspected cases of ureteral stone. Because of the highly improved x-ray technique employed at the present time very few stones are invisible to the x-ray, and even those that are slightly opaque can be visualized. The nonopaque, uric acid stone is rare, and is overlooked when one depends on the x-ray for its diagnosis. We have observed only two proven cases presenting this type of uric acid calculus. The most valuable x-ray sign is the insertion of the opaque catheter or bougie into the ureter, and the demonstration of the contact of said catheter with the opaque stone. A calcified gland, phlebolith, sclerotic artery, enterolith, fecolith, or foreign body in the intestines or shadow in the pelvic bones may appear to be in contact with the opaque catheter, and may be mistaken for ureteral stone. Stereoscopic films taken at different angles, both in the lateral and anterior posterior positions, are necessary in order to clarify the diagnosis in these cases. On the other hand, the shadow cast by a stone located in the other ramus of a bifid ureter, or in a diverticulum, may appear to be out of the ureter. As duplication of the ureter occurs in about 4 per cent of patients, further investigation by ureteropyelography is necessary in order to detect the occasional ureteral calculus that lodges in the bifid ureter, or in a diverticulum of the ureter.

Ureteropyelography is of great assistance. It enables one to locate the stone in the ureter, to demonstrate its obstructing effect, and to visualize the amount of damage producing dilatation of the ureter and pelvis above. The taking of fractional films after withdrawal of the catheter, or after the intravenous injection of one of the opaque solutions now at our command, demonstrates the amount of obstruction caused by the impeding stone. The employment of intravenous urography is of great value, particularly in those cases in which one is unable to pass the ureteral bougie above the stone. Unfortunately, it is not as precise as retrograde urography. When kidney function is inhibited, very little dye is excreted by the impaired organ, and poor ureterograms result. In fact, in some patients with impaired renal function we have noted that the dye has not been eliminated in sufficient concentration to cast any shadow at all. In some of these cases suppression of renal function was not due to total destruction of the kidney, because, after the obstructing stone was removed, renal function returned to normal, as determined by making the indigocarmin and phenolsulphonephthalein dye tests or by subsequent employment of intravenous urography.

The diagnosis of ureteral calculus depends upon a careful history, complete urine analysis, employment of the x-ray and intelligent interpretation of findings obtained by cystoscopic study and ureteral catheterization. In differentiating ureteral calculus from appendicitis, gall-bladder disease and other lesions of the gastro-intestinal tract, the finding of blood in the urine is quite significant. Intravenous urography indicates that the trouble is in the upper urinary tract. Precise diagnosis, however, still depends upon cystoscopy, the passage of opaque ureteral catheter and the employment of the x-ray, including stereoscopic films and ureteropyelography. With intelligent interpretation of the findings obtained by the improved diagnostic methods now at our command, 98 per cent of ureteral stones can be accurately diagnosed.

* * *

III. TREATMENT

ROGER W. BARNES, M. D. (746 Francisco Street, Los Angeles).—The proper management of the case of ureteral calculus is an individual problem. The treatment may be (1) expectant, (2) manipulative, or (3) surgical, depending upon several factors, the chief of which are the size of the calculus, the position of the calculus, and the amount of complicating infection, all of which the diagnosis has determined.

Expectant treatment may be used when the calculus is less than 2 millimeters in diameter and there is no renal infection, or when a diagnosis of calculus has been made from the symptoms, physical examination, and urinalysis, and roentgenograms show no shadows resembling calculus. It consists of sedation in sufficient amount to relieve the pain, and an antispasmodic, such as atropin, to relieve the ureteral spasm. It has been shown that opiates do not relax the smooth muscle of the ureter. The patient should take at least 3,000 cubic centimeters

of fluid in twenty-four hours, and bed rest is not necessary; in fact, it is probable that the calculus will pass more rapidly if the patient is up. Expectant treatment should not be continued if infection occurs, or if the patient is disabled for more than ten days due to repeated attacks.

Manipulative treatment is accomplished by means of bougies, catheters, and dislodgers through the cystoscope, and is indicated when there is renal infection, when a small calculus does not pass and causes recurrent attacks of colic, and when the calculus is more than 2 millimeters and less than 1 centimeter in diameter. Most stones larger than 1 centimeter require open operation unless they are near the ureteral orifice. The kind of cystoscopic manipulation used varies greatly, and depends upon the training and experience of the cystoscopist; but all urologists agree on certain fundamental principles. If there is infection in the kidney above the stone, it is important to establish drainage of the renal pelvis by passing a catheter, or if possible several small catheters or bougies, by the stone, and leaving them in place for from one to four days. When these are removed, the calculus will often follow in a day or two without further manipulation. If there is no renal infection and only slight disability due to pain, a more gradual dilatation of the ureter is accomplished by means of treatments at intervals of seven to ten days, using bougies of increasing sizes which are passed up to or above the calculus through the cystoscope; or, if the stone is within 4 or 5 centimeters of the ureteral orifice, it may be possible to engage it in a ureteral calculus dislodger of some type, and remove it. Inasmuch as the ureteral orifice is the narrowest portion of the ureter, it is frequently necessary to incise this by means of cystoscopic scissors or an electrocutting instrument in order to obtain passage of the stone. Because of edema of the ureteral mucosa caused by manipulative treatment, it is useless to repeat the treatment more often than once a week, and in the interval the patient is treated expectantly. Cystoscopic manipulation must always be carried out with the utmost gentleness, for injury of the urinary passages increases the patient's pain, obstructs urinary drainage, predisposes to infection, and is frequently followed by stricture formation. With our present-day armamentarium of urinary antiseptics, renal infection can be controlled much more readily than formerly. Alternating a mandelate preparation such as calcium mandelate, grains xv, t. i. d. for a week with sulfanilamide, grains xv, every four hours for two days, grains x every four hours for two days, then grains v every four hours for two days, will aid greatly in controlling infection, and will frequently eliminate it entirely. The patient must be watched closely for toxic symptoms while he is taking the sulfanilamide, and the drug discontinued if they are pronounced. During the progress of expectant and manipulative treatment, observation of the kidney for possible damage due to obstruction from the utereral calculus must be frequently made; and if it is shown by differential functional tests, by pyelographic study, or by signs of continued infection in the kidney, that renal damage is progressing, these types of treatment should be abandoned and ureterolithotomy resorted to. This is especially true in the case of bilateral ureteral calculus, and in cases which have an absence of, or a previously damaged, opposite kidney.

Surgical treatment is indicated when the calculus cannot be removed cystoscopically because of its size, shape, or position in the ureter, and when renal infection due to obstruction by the stone cannot be adequately controlled. Most calculi which are 1 centimeter in diameter or more cannot be moved down the ureter into the bladder, especially if they are located in the upper two-thirds of the ureter; sometimes a stone which has sharp projections on its surface will become impacted in the ureter, and cannot be dislodged by cystoscopic manipulation; and occasionally a ureteral stricture or kink just below a calculus will prevent successful dilatation. In these cases ureterolithotomy must be resorted to. The surgical approach depends upon the position of the stone: if it is below the upper edge of the sacro-iliac joint, a low midline, extraperitoneal approach gives the best exposure; and if above this point, a lumbar incision with the patient in the kidney position is indicated. A convenient but little used approach is the vaginal route which may be indicated in multiparous women when the calculus is low and can be palpated through the vaginal wall. A neglected ureteral calculus may result in kidney damage to such an extent that removal of the kidney and sufficient ureter to include the stone is necessary.

Prophylactic treatment is indicated in every case of urolithiasis. It consists of establishing and maintaining free urinary drainage, eliminating urinary tract infection, controlling the reaction of the urine, and supplying dietary deficiencies. The treatment of the patient with ureteral calculus does not end with the removal of the stone; on the contrary, he is kept under observation and treated until there is a normally functioning urinary tract. If fibrosis and ureteral stricture have resulted from the calculus, ureteral dilatation is continued until free drainage is assured. If renal infection persists, urinary antiseptics and, sometimes, kidney pelvic lavage are necessary to remove this infection. Inasmuch as the reaction of the urine is a factor in producing urinary calculi, an examination of the stone after removal, or a pH determination of the urine will aid in directing prophylactic treatment. If the calculus is phosphatic and the urine is persistently alkaline, medication, such as ammonium chloride, sodium acid phosphate, or nitrohydrochloric acid, and an acid-ash diet, is indicated to change the reaction of the urine; whereas if the urine is excessively acid, an alkalizing program is given until a near neutral reaction is obtained. Deficiencies in diet and an insufficient water intake are proven factors in the causation of urinary lithiasis, and prophylactic treatment includes a diet list which is high in vitamins A and D, or supplementing the diet with haliver oil or other vitamin preparations. The patient should also form the habit of drinking 3,000 cubic centimeters of water in twenty-four hours if he wishes to avoid a recurrence of the ureteral calculus.

Prognosis.—When the patient suffering with a ureteral calculus is seen in the early stages of the disease, and is managed intelligently, there is very little question but that the outcome will be favorable. However, in cases which are neglected or incorrectly treated, complications may arise which become very grave, and may result fatally. Concurrent diseases, especially cardiovascular or renal, may change what would otherwise be a good prognosis into a poor one; for these patients do not tolerate cystoscopic manipulative procedures any better than they do surgical procedures.

The recurrence of ureteral calculi depends to a great extent on the prophylactic treatment carried out after the removal or passing of a stone. Statistics on recurrence differ greatly, and vary from those of Jeaubrau, who reported only two cases of recurrence in 220 patients treated, to those of Rosving and others, who report recurrences in almost half of the cases they have collected. In the average urological practice approximately 15 per cent of the cases give a history of having had previous attacks of colic which had been diagnosed as ureteral stone. It is probable that this percentage will be reduced considerably when prophylactic treatment is more widely used.

Aid for the Medical Witness.—The courtroom is an unfamiliar and often dreaded territory. Far pleasanter places than the witness chair can be imagined. However, every doctor faces medico-legal problems and controversies. With tomorrow may come a summons to appear in civil or criminal court as a factual or as an expert witness. The doctor's importance as an aid to the administering of justice has been accelerated by this modern age of speed and of machines. Automobile accidents and industrial accidents have increased. Occupational diseases have come into prominence. Workmen's compensation, employers' liability, trade-unions and in some states, industrial accident commissions, are modern developments.

As a result, the vast and intricate subject of medical jurisprudence becomes of greater concern and import. It has been noticed in the library of the Society that books on legal medicine and its ramifications are an increasing demand. A wealth of material is available. The library possesses an unusually rich collection of volumes on fraud and malingering forensic medicine, toxicology, court cases, criminology, industrial hazards, legal phases of psychiatry, compensation insurance, and so on. There is also an almost unlimited amount of material to be found in the periodical indexes.

While interest in these various phases of legal medicine is somewhat sudden, the subject is older than the printed page. Historical instances of the simulation of disease abound. Zacchàis, a physician of Rome (1620) wrote the first classical treatise on the medico-legal aspect and established principles that are sound today. In 1650 Michiaelis of the University of Leipzig gave the first lecture on legal medicine and a century later professorships were founded in Germany. In 1803 a chair of Forensic Medicine was established at the University of Edinburgh. In 1876 Dr. S. E. Chaillé, in a masterly address on the development of medical jurisprudence, a subject dear to his heart, wrote: "The states have as yet made no demand for competent medical experts to aid the administration of justice, and have done nothing designedly for the culture of medical jurisprudence."

Progress has been made since that day. Medical witnesses may, through reading and study, give evidence in the most forceful and effective manner. From "Frauds in Medical Practice," by the noted authority, Sir John Collie, we take these rules for giving evidence:

1. Speak slowly and distinctly.

2. Watch the judge's pen. When he stops writing resume your evidence.

3. Look at counsel as he propounds his questions, but direct your reply to the judge and the jury.

4. Answer the exact question put. If any explanation or amplification is necessary, the witness has a right to give it after giving a direct answer.

5. In giving medical advice, one must be careful not to give the court the impression that you know it has not any really sound knowledge on medical subjects.

6. Nothing is more effective than to take into the witness box a model or picture. This always impresses both the judge and the jury. One can often make a fracture quite clear by showing a bone.

7. A medical witness can always take his notes with him into the witness box and refresh his memory from them *if and only if they are the original notes which he took at the time of his examination.*

8. Seldom, if ever, use technical language; if it is imperative to do so, explain it.

9. Make sure that your process of reasoning is abundantly clear.

10. Put aside all bias, and be absolutely candid. Remember that you have sworn not only to tell "the truth," but "the whole truth." This, I take it refers to *suppressio veri.* Do not hesitate to admit a fact which may at first sight appear to be against your contention. You will probably be able to demonstrate that it is not so in reality. In any event, the admission will demonstrate such fairness that the remainder of your evidence will have an advanced value.

11. A medical witness should be scientifically exact, lucid and succinct.

12. Remember that, in medicine at any rate, anything is possible; therefore, get the credit of willingly admitting it.

13. Never give evasive answers.

14. Never guess.

—The Bulletin, Orleans Parish.

Sulfanilamide May Prove Valuable in Treatment of Tularemia.—That sulfanilamide may eventually prove of value in the treatment of tularemia is indicated in the report of one case, in *The Journal of the American Medical Association,* so treated by Walker L. Curtis, M. D., College Park, Georgia.

Tularemia is generally contracted from infected rabbits. While one is dressing such rabbits the infection can easily pass into his blood stream through a scratch or abrasion of the skin.

The case reported by Doctor Curtis occurred in a middle-aged woman who was suffering from chills, fever, nausea, vomiting, and headache. Her condition grew steadily worse: to the general symptoms were added mild pain in the right arm and more severe pains over the chest and right upper quarter of the abdomen; she became weaker and somewhat irrational.

"Two days after the administration of sulfanilamide," the author states, "the symptoms of tularemia, severe for more than two weeks, subsided and convalescence has been uneventful. So far I have found no report of an earlier case of tularemia successfully treated with sulfanilamide.

"After the patient had recovered she recalled that a week before she became ill she had taken some dressed rabbits from salt water and wrapped them up. The nature of her occupation was such that she often had scratches and abrasions of her hands."

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

CHARLES A. DUKES.....President
HARRY H. WILSON.....President-Elect
LOWELL S. GOIN.....Speaker
KARL L. SCHAUPP.....Council Chairman
GEORGE H. KRESS.....Secretary and Editor

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COUNTY MEDICAL SOCIETIES: REPORTS

WOMAN'S AUXILIARY TO THE C. M. A.

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Two Hundred and Seventy-Eighth (278th) Meeting of the Council of the California Medical Association

Held in Room 209, Hotel Sir Francis Drake, San Francisco, Saturday, August 5, 1939, at 9:30 a. m.

1. Call to Order.

The meeting was called to order by Chairman Schaupp.

The following members were present: President Charles A. Dukes, President-Elect Harry H. Wilson, Past President William W. Roblee, Speaker Lowell S. Goin; Councilors Calvert L. Emmons, George D. Maner, Louis A. Packard, Axcel E. Anderson, C. Kelly Canelo, Karl L. Schaupp, Frank A. MacDonald, Henry S. Rogers, William H. Kiger, P. K. Gilman, E. Earl Moody, Elbridge J. Best, Frederick N. Scatena; Chairman of Public Relations Committee George G. Reinle, Secretary-Editor George H. Kress. Present by invitation: Vice-Speaker Dewey R. Powell, Chairman of Committee on Public Health Education Frank R. Makinson, and Legal Counsel Hartley F. Peart and Associate, Howard Hassard.

Absent: Doctors C. O. Tanner and O. D. Hamlin.

2. Condolence to Hall G. Holder.

A telegram from C. O. Tanner was read, stating that his absence was occasioned by the death of the daughter of Dr. Hall G. Holder, President of the San Diego County Medical Society, whose work he was assuming.

The Secretary was instructed to forward a telegram to Doctor Holder, expressing the deep sympathy of the Council in his loss.

3. Minutes of the Council.

It was moved by Charles A. Dukes, seconded by Harry H. Wilson, that the minutes of the 277th meeting of the Council be approved. Carried.

4. Minutes of the Executive Committee.

It was moved by Charles A. Dukes, seconded by Harry H. Wilson, that the minutes of the 156th meeting of the Executive Committee be approved. Carried.

5. Mail Vote on Newspaper Publicity.

Report was made on the mail vote of the Council concerning action taken at the Council meeting held on June 3 (items 23 and 46). Chairman Schaupp stated it was necessary to proceed promptly in the matter, if the newspaper announcement was not to appear. Dr. Lowell S. Goin raised a question of parliamentary procedure and, after discussion, it was moved by Harry Wilson, duly seconded and carried, that the Council sustain the objections of Doctor Goin, but approve the courage of the Chairman of the Council and of other officers of the Association in acting for the best interests of the Association.

It was agreed that proper parliamentary procedure should be adhered to at all times so that there would be no abuse of privilege.

6. Financial Statements.

Financial statements for the months of June and July, 1939, were presented.

The Secretary reported that, at the present time, $10,000 cash was available in the California Medical Association accounts; that California Physicians' Service had borrowed $5,000 on the $15,000 loan approved for its work, leaving a balance of $10,000 that might be called for; that the California Medical Association Cancer Exhibit at the Golden Gate International Exposition had a drawing account on its original allocation of $5,000, of approximately $1,500; that, of the $20,000 borrowed on security of United States Government Bonds from the Trustees Of The California Medical Association, $5,000 had been repaid by the California Medical Association, leaving a balance of $15,000 due the Trustees from the California Medical Association.

It was moved by Charles A. Dukes, seconded by A. E. Anderson, that the financial reports for the months of June and July, 1939, be approved. Carried.

7. Membership.

Association Secretary Kress reported that on July 31 the membership was 6,123; and that 325 new members had joined the Association during the current calendar year.

8. Retired Membership.

The Secretary presented requests for retired membership from various county medical societies.

It was moved by Calvert L. Emmons, seconded by A. E. Anderson, that retired membership be granted Dr. George Deacon, Los Angeles County Medical Association; Dr. R. A. Buchanan, San Joaquin County Medical Society; Dr. Dwight D. Johnson, Placer County Medical Society; Dr. Alfred H. Tickell, Placer County Medical Society; Dr. C. J. Schmelz, Sonoma County Medical Society; and Dr. Clark J. Burnham, Sr., Alameda County Medical Association. Carried.

9. Affiliate Fellowship in American Medical Association.

A letter was presented from the Council of the Los Angeles County Medical Association requesting the Coun-

† For complete roster of officers, see advertising pages 2, 4, and 6.

cil of the California Medical Association to recommend to the American Medical Association House of Delegates that affiliate fellowship be granted William H. Gilbert of Los Angeles.

It was moved by George D. Maner, seconded by William H. Kiger, that William H. Gilbert be recommended by the Council for affiliate fellowship in the American Medical Association. Carried.

10. **Premarital Examinations.**

A letter was presented from Dr. Russell V. Lee, Chairman of the Planning Committee of the American Social Hygiene Association, which had been sent to all component county medical societies, suggesting that physicians make, without cost, the examinations stipulated in the premarital law enacted by the recent California legislature.

It was moved by Harry H. Wilson, seconded by George Maner, that it is the belief of the Council that members of the California Medical Association approve the new law, and that, as regards professional services to citizens coming under the Act, individual physicians would be happy to take into consideration the financial backgrounds of citizens; and further, that, in the matter of fees, physicians should be guided by the practice and principles followed in their respective communities; and, also, that the fees to be charged are matters for determination by the individual physicians and the patients. Carried.

11. **Committee on Public Health Education.**

Frank R. Makinson, Chairman of the Committee on Public Health Education, the committee that is charged with the responsibility of carrying forward the work contemplated by the House of Delegates Substitute Resolution No. 6, with funds provided through the Special Assessment levied as of June 11, 1939, submitted the following report:

"Pursuant to our appointment and a call for a committee meeting by Chairman of the Council Karl L. Schaupp, the Committee met in Sacramento on June 11, 1939, organized and proceeded to work. Since that time all members of the Committee have diligently applied themselves to their assigned task.

"After considerable discussion it became evident that the resolution, under which the Committee was created, was capable of broad and liberal interpretation. It was deemed neither desirable nor feasible to parallel, duplicate, or overlap the function of other existing committees, such as the Public Relations Committee and the Committee on Public Policy and Legislation. Therefore, this Committee recommended to the Council of the California Medical Association that the present Committee on Public Policy and Legislation be designated as the "Executive Group" of the Committee on Public Policy and Legislation, with the accepted powers and duties of an executive group. Since the Committee on Public Health Education interprets its instructions to include the work of the Committee on Public Policy and Legislation in policies regarding our economic and political interests, and also in carrying on the program of education in public health welfare, it was deemed more advantageous to combine the activities of the two committees in this phase of the work. The knowledge, technique, and instrumentalities of the Committee on Public Policy and Legislation are well known and should in no way be displaced by another committee less skilled in that art. Therefore, in order to extend and aid the work of that committee, the Committee on Public Health Education recommended that its budget include an item for allocation to the Committee on Public Policy and Legislation of $500 monthly, and that any necessary additional requirements be covered by allocations as occasions might arise.

"Public Relations Counsel: The matter of the employment of a public relations counsel was discussed at great length and the names of applicants for this position were presented and carefully canvassed with the result, that the name of Mr. Ross Marshall has been recommended to this Council as the man possessed of the best qualifications who shall be employed on an annual basis, with the proviso that the contract could be terminated by either party on a sixty-day notice, compensation to be fixed at $100 per week. The Public Relations Counsel would at all times be working under the direction of the Chairman of the Committee on Public Health Education. In order to secure the greatest amount of information on what might best serve as a guide to the activities of this committee, I addressed myself to Dr. Edwin L. Bruck of San Francisco, Dr. G. W. Walker of Fresno, Dr. John H. Shepard of San Jose, and Dr. Samuel Ayres, Jr., of Los Angeles, all of whom had presented separate resolutions on this subject to the House of Delegates at Del Monte, as recorded in the June issue of the OFFICIAL JOURNAL. (Resolutions 6, 8, 12, and 13)."

The letter sent to each of the sponsors of the four resolutions used by the Del Monte Reference Committee in formulating Substitute Resolution No. 6, was read by Doctor Makinson, and follows:

Dear Doctor:

The House of Delegates Committee on Public Health Education has had two meetings, and finds that the problem before it is much more difficult and complex than appeared at first.

The committee takes a broad view of the subject, and feels that the program should be educational and very complete. It should coördinate plans having to do with:

(*a*) Education of the profession in relation to its obligation to its own members, patients, to the public and government officials;

(*b*) Education of the public as to what is being done by medicine for the public health, by appearing at meetings and conventions, newspaper articles, etc.

(*c*) Education of the public officials in relation to the public health and public welfare; and

(*d*) The best dissemination of information and medical facts by members of an information bureau.

The purpose of this letter is to confer with you as one of the authors of the resolution which brought this committee into being. We ask your further help by suggestions for our guidance in continuing this work.

A self-addressed envelope is enclosed. We hope that you will kindly send such suggestions as you have, in order that we may have a report for the Council, which will meet on August 5.

Very truly yours,

Committee on Public Health Education,
By Frank R. Makinson, M. D., Chairman.

"In response to the above letter, replies were received from the sponsors of the four Del Monte resolutions, which the reference committee, of which Doctor Powell was chairman, took into careful consideration, after full discussion with proponents, in preparing Substitute Resolution No. 6, which was adopted by the House of Delegates on May 3.

"The replies received from the sponsors of the resolution referred to indicate that the plans contemplated by the Committee on Public Health Education are in general harmony with the views expressed. The suggestions received will receive careful consideration by our Committee."

Further discussion concerned plans under consideration, as well as of the present and ultimate amounts in the special assessment fund. It was pointed out that only such work could be undertaken as the funds in hand made possible.

Dr. Dewey R. Powell, Chairman of the Reference Committee on Resolutions, who had discussed all the original resolutions with their sponsors when the substitute resolution was prepared, then addressed the Council, explaining the nature of opinions presented to the Reference Committee at Del Monte that led to the drafting of Substitute Resolution No. 6.

Discussion was then had of the employment of a public relations counsel. An interpretation of the words "full-

time public relations counsel," as included in the resolution, was asked of the General Counsel, Mr. Peart.

It was pointed out that the Committee on Public Health Education had interpreted the phrase to mean a man who is engaged in public relations entirely and who is always at its service. The General Counsel stated there are two possible interpretations of the phrase "full time," either of which may be considered a correct interpretation, and accordingly the Committee's construction can be considered proper.

It was moved by Charles A. Dukes, seconded by Frank A. MacDonald, that the interpretation of the Committee on Public Health Education, that the term "full-time public relations counsel" is a man who is engaged in public relations exclusively and who is always at its service, be approved. Carried.

The practice of allocating funds of the Special Assessment Fund to other committees for activities was discussed.

It was agreed that the recommendations of the Committee on Public Policy and Legislation be incorporated in the recommendations of the Committee on Public Health Education for approval by the Council.

The proposed basic science law, as now being drafted by the Committee on Public Relations, was discussed, and it was felt that, after completion of the draft and approval by the Council, it could well be referred to the Committee on Public Health Education for such educational publicity as might be needed.

It was suggested by Doctor Maner that the Committee on Public Health Education might send a bulletin to members of the profession at monthly intervals, advising members of the work of the Committee.

12. Recess.

At this point a recess of the Council was declared, to permit a meeting of the Board of Directors of the Trustees Of The California Medical Association.

13. Call to Order.

The Council was called to order after the recess by Chairman Schaupp.

14. Loan from Trustees Of The California Medical Association.

It was moved by Lowell S. Goin, seconded by C. A. Dukes, that the California Medical Association borrow from the Trustees Of The California Medical Association a sum not to exceed $25,000 at the joint discretion of the President, Secretary, and Chairman of the Auditing Committee.

15. Public Relations Counsel.

Mr. Ross Marshall, who had been interviewed regarding the position of public relations counsel for the Committee on Public Health Education, outlined plans for publicity, as contemplated under the provisions of the resolution of the House of Delegates.

16. Special Assessment.

The Association Secretary reported that approximately 3,650 members had paid the special assessment of $10.

Discussion was had of method of payment of bills incurred by the Committee on Public Health Education. It was agreed that any expense incurred for work authorized by the Council would be approved for payment upon approval of the Auditing Committee of the California Medical Association without further resubmittal to the Council. It was agreed that expenses should be approved by the Chairman and Secretary of the Committee on Public Health Education before being passed to the California Medical Association Auditing Committee for payment.

On motion duly made, seconded and carried, it was voted that the Council approve the recommendations of the Committee on Public Health Education, including the employment of Mr. Marshall as Public Relations Counsel, and the $500 allocation to the Committee on Public Policy and Legislation. Further, that the current bills of the Committee be paid upon approval by the Auditing Committee. Also, that the allocations be paid in regular order, unless a change in policy is involved, in which case recommendations for activities must be resubmitted to the Council, before expense is incurred. Carried.

Discussion was had of the resolution of the House of Delegates with particular reference to the penalty of forfeiture of membership for nonpayment of assessment within sixty days from date of levy, and the constitutional provisions covering loss of membership, as outlined in correspondence with Dr. George Maner, Secretary of the Los Angeles County Medical Association, were commented upon by Legal Counsel Hartley F. Peart.

On motion of Lowell S. Goin, seconded by Louis A. Packard and Charles A. Dukes, the following resolution was adopted:

WHEREAS, The House of Delegates, believing that a program of public education was desirable and essential, adopted a resolution at the last annual meeting held at Del Monte, May 1–4, 1939, authorizing and directing that a special assessment of $10 be levied upon each active member as of June 1, 1939, and providing that failure to pay such special assessment within sixty days should forfeit membership in the Association; and

WHEREAS, The House of Delegates was fully authorized under the constitution to levy the special assessment, but exceeded its power under the existing constitutional and by-law provisions in applying the penalty of forfeiture of membership for failure to pay the same; and

WHEREAS, The Council believes that each member realizes the necessity of undertaking such educational work, and will loyally support the organization with the necessary funds therefor; now, therefore, be it

Resolved, That the Council of the California Medical Association interprets the Constitution and By-Laws to mean that the House of Delegates was clearly within its rights in levying such special assessment, but exceeded its powers in applying a penalty; and be it further

Resolved, That the Association secretary forthwith notify the secretary of each component county medical society, and each active member of the Association, of the adoption of this resolution, setting forth the program of the Committee on Public Health Education this day approved, requesting the payment of the special assessment and the coöperation of each member and his suggestions for the committee and the Council.

Doctors Gilman and Best voted no on the adoption of the resolution.

After further discussion of the complications which had arisen, particularly in connection with the penalty clause, as included in the Del Monte Substitute Resolution No. 6, it was agreed that the Committee on Public Health Education, through its chairman, Dr. Frank R. Makinson, should formulate an informative letter, to be sent out from the California Medical Association central office to all members of the California Medical Association. This letter to outline the background, work and plans of the newly created Committee on Public Health Education, and to call attention to the action of the Council in interpreting the penalty clause to have been inserted without authority from the Constitution and By-Laws of the Association, and that it was, therefore, nonoperative.

It was moved by Harry Wilson, seconded by Calvert Emmons, that the Secretary-Treasurer be instructed to notify the county society secretaries that they had authority to collect the assessment, either as a cash payment or a letter of agreement, or part payments, the same to be forwarded to the California Medical Association when the full assessment had been collected.

17. California Physicians' Service.

C. Kelly Canelo, member of the Board of Trustees of the California Physicians' Service, presented a letter from the Executive Committee of the Trustees, asking that the Council give consideration to the possibility of increasing the number of professional members of the California Physicians' Service in certain counties.

T. Henshaw Kelly, member of the Executive Committee of the Trustees of the California Physicians' Serv-

ice, stated that the policies of the organization had been printed, and presented copies to the Association for its files, together with descriptive pamphlets of the service offered, and also a copy of the Rules and Regulations.

18. **Noon Recess.**

At this point a recess for luncheon was taken.

19. **Call to Order.**

Chairman Schaupp called the Council to order after the noon recess.

20. **Basic Science Law.**

The Association Secretary reported that, in accordance with the instructions of the Council, the Committee on Public Relations was drafting a Basic Science Act under supervision of a committee in the North, of which Dr. Dwight Wilbur is chairman, and one in the South, of which Dr. Donald Cass is chairman. The final draft would be in the form of an initiative. The Council to decide whether a place for this proposed initiative should be sought on the November, 1940, state election ballot. It was stated that an expression of opinion of members of the Association would be obtained by the Committee on Public Health Education. Mr. Hassard, of the Legal Counsel's office, stated he was assisting Dr. Dwight Wilbur on the legal phases of the proposed Basic Science initiative.

It was suggested that, in the letter that would be sent to California Medical Association members concerning the special assessment, request could be made that members of the Association indicate whether they felt the Association should place a basic science initiative on the state election ballot of November, 1940.

21. **Chiropractic Initiative.**

The Association Secretary reported on the activities of the Committee on Public Relations in relation to the chiropractice initiative, and presented a letter from the Board of Medical Examiners in which comment was made on the scope of the chiropractic initiative which, by ruling of the Attorney-General of California, will find a place on the special election called by Governor Olson, and to be held during the present year, on November 7, 1939.

It was moved by George Maner, seconded by Charles Dukes, that the Council go on record as being opposed to the chiropractic initiative. Carried.

Further discussion on future course in the matter was then had.

22. **Indemnity Defense Fund.**

The Association Secretary called the attention of the Council to the financial status of the Indemnity Defense Fund, now under the custodial care of three trustees—Dr. Lemuel P. Adams of Oakland, Dr. Junius B. Harris of Sacramento, and Dr. Howard Morrow of San Francisco. Report was given on the assignments that had been made in favor of the California Medical Association, and also on the nonassignments.

It was moved by A. E. Anderson, seconded by E. Earl Moody, that the General Counsel and the Secretary be authorized to check on the assignments, and then draft a letter to be sent to members of the Indemnity Defense Fund who have not yet signed agreements of assignment. Carried.

23. **Appeal of A. T. Martin.**

Association Secretary Kress read a letter, dated July 18, 1939, from Albert T. Martin, giving notice to the California Medical Association of his appeal from the decision of the Council of the Los Angeles County Medical Association on charges preferred against him on May 13, 1939.

It was moved by Charles A. Dukes, seconded by A. E. Anderson, that the Council fix the date of the hearing for the appeal of A. T. Martin against the decision of the Los Angeles County Medical Association to be 10 a. m., Saturday, October 7, 1939, in the Headquarters Building of the Los Angeles County Medical Association, 1925 Wilshire Boulevard, Los Angeles. Carried.

It was moved by E. Earl Moody, seconded by A. E. Anderson, that the Committee on Conciliation in the hearing of A. T. Martin consist of William W. Roblee (chairman), Calvert L. Emmons, and C. O. Tanner. Carried.

24. **Washington State Medical Association.**

On motion duly made, seconded and carried, President Dukes was authorized to present greetings from the California Medical Association at the Golden Jubilee of the Washington State Medical Association, and necessary travel expense was approved.

25. **California Physicians' Service.**

Further discussion was had of the work of the California Physicians' Service.

It was moved by Harry H. Wilson, seconded by E. Earl Moody, that a committee, consisting of Doctors Charles A. Dukes, President; Karl L. Schaupp, Chairman of the Council; and C. Kelly Canelo and T. Henshaw Kelly, members of the Trustees of the California Physicians' Service, represent the California Medical Association at a meeting of the Sacramento Society for Medical Improvement, to aid in furnishing information requested; and that the coöperation of the Sacramento Society for Medical Improvement in the work of the California Physicians' Service be requested. Carried.

It was moved by A. M. Moody, seconded by George D. Maner, that the Council fully endorse the activities of the Board of Directors of the California Physicians' Service and again urge the Board of Trustees of the California Physicians' Service to proceed with all due diligence in writing contracts. Further, that the Council fully appreciated the arduous duties and the immense amount of work which had been accomplished. Carried.

26. **County Hospitals.**

Discussion was had of the County Hospital situation.

A letter from the Association of California and Western Hospitals was presented.

It was moved by Charles Dukes, seconded by Louis Packard, that the Western Hospital Association be informed that its requests for specific information should be presented in writing, for consideration by the Council or its delegated committees.

It was moved by Louis Packard, seconded by A. E. Anderson, that an appropriation of $2,500 be made for work in connection with county hospitals. A vote was taken; motion was defeated.

27. **Legal Expenses.**

It was moved by Lowell S. Goin, seconded by C. A. Dukes, that legal expense of $500 be authorized in an appeal case. Carried.

28. **Press Releases.**

The Association Secretary reported that the Committee on Public Relations was sending, weekly, the "American Medical Association News" press releases on advances in scientific medicine, to a selected group of newspapers in California.

29. **Municipal License Taxes.**

The Central Office reported that several inquiries had been received regarding the legality of taxes on physicians by cities and counties, and that information thereon had been forwarded in accordance with the instruction of the legal department.

30. **Nostrums and Quackery.**

The Council was advised of the coöperation between the Association and the Federal Trades Commission in efforts to eliminate nostrums and quackery.

31. **Federal Health Legislation.**

The Association Secretary submitted a progress report on the status of proposed Federal health legislation as contemplated in S. B. 1630 and H. R. 6635.

32. **Woman's Auxiliary.**

The proposed amendment to Section 1 of the By-Laws of the Woman's Auxiliary, regarding a nominating committee, was presented.

It was moved by Charles A. Dukes, seconded by A. E. Anderson, that the proposed amendment to the By-Laws of the Woman's Auxiliary be approved. Carried.

The Secretary read the outline of plans and policies of the Woman's Auxiliary as submitted from Mrs. Frederick N. Scatena, President.

On motion duly made, seconded and carried, the program of the State Auxiliary was commended.

It was moved by Charles A. Dukes, seconded by William H. Kiger, that the Committee on Scientific Work arrange for a three-minute address by the president of the Woman's Auxiliary at the first general meeting of the next annual session. Carried.

33. **Inyo-Mono County Society.**

The Council was advised that the charter of the newly organized Inyo-Mono County Medical Society had been forwarded, and that this county unit was now in active operation.

34. **Needy Physicians.**

Axcel E. Anderson reported that, in accordance with the resolution of the House of Delegates adopted at Del Monte, the Committee on Needy Members, consisting of Doctors Peers, Anderson, and Hohl, had been at work and that a meeting of the Committee was desired.

On motion duly made, seconded and carried, transportation expenses were authorized for a meeting of the Committee on Needy Members.

35. **Next Meeting.**

Upon motion, duly made and seconded. it was voted that the Council shall hold its next meeting in Los Angeles on Saturday, October 7, 1939. Hearing of the appeal of Dr. A. T. Martin to be heard at 10 a. m. on that day.

36. **Adjournment.**

There being no further business, the meeting adjourned.

KARL L. SCHAUPP, *Chairman.*
GEORGE H. KRESS, *Secretary.*

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

SOCIALIZED MEDICINE*

What Is Best Course for Doctors?

Pithy Questions Asked

Shall we turn medicine over to politics? Shall we make doctors and surgeons into politicians, or men dependent on politicians? Shall we degrade a great profession and the service it renders? These are some of the questions which the drive for socialized medicine is bringing to the fore. No doubt the profession of medicine is like most other professions in need of improvement. But is improvement to be found in control of medicine by the state?

American doctors seem to have done a really fine job. They have diminished the general death rate very rapidly as well as the special death rates for such common and heretofore deadly diseases as diphtheria, scarlet fever, yellow fever, smallpox, typhoid, and tuberculosis. In fact, they lead the world in control of such diseases. In the last fifty years the expectancy of life has been more than doubled in our country.

On the other hand, in countries where social medicine has been provided by a state, progress has been slower.

A fair conclusion seems to be that the reforms required in medicine will be achieved more effectively and cheaply, and with far better results measured in human welfare, by keeping medicine out of the hands of politicians who, presumably, would include it, as they have included relief, in a sordid game of patronage, graft, and personal aggrandizement.

One might rather bluntly sum up the question by asking, do the people want to pay from half a billion to a billion more taxes each year in order to have their doctors chosen and their medical service controlled by the kind of men that hang around the courthouse?—Pasadena *Star-News.*

DOCTORING NOT A TRADE‡

A rebuff anticipated in most informed quarters was administered yesterday to the Government when the Federal District Court of Washington, D. C., ruled out the "trust-busting" charges brought against the American Medical Association. In holding the practice of medicine to be a learned profession and not a trade and, therefore not subject to the Sherman Act, the Court affirmed a view generally held by jurists. Untouched, however, is the basic question whether the Association is on sound ground in its opposition to so-called "group medicine," which formed the peg on which the Government hung its punitive action.

If the decision is appealed and the Supreme Court sustains it, the whole question of voluntary group medicine, as opposed to "state medicine," will go back where it belongs—up to the physicians and the public. In such case there is every reason to believe that a workable system of private group health insurance can be devised along lines laid down in California and elsewhere.

ARMY DOCTORS ORDERED TO PAY REGISTRATION FEE

Army, Navy, and United States Public Health Service doctors, who have not paid their annual registration fee to this state, are not permitted to have a private practice, Attorney-General Earl Warren ruled today.

Warren, in his opinion, directed to Dr. Charles B. Pinkham, Secretary-Treasurer of the Board of Medical Examiners, stated that Government doctors do not forfeit their medical licenses, but do lose their right to practice within the state sixty days following commencement of the taxable year, January 1, 1939.—San Francisco *Call-Bulletin,* July 13.

A GLANCE AT THE CALIFORNIA LEGISLATURE'S RECORD

Our 1939 State Legislature closes its second longest session in the state's history without enacting a single piece of major legislation unless the Oil Control bill ranks that rating—and notice is given by its opponents that it will have to stand the test of a referendum vote.

But our legislators might easily have done much worse, as, for instance, yielding to the Compulsory Health Insurance propagandists, seeking to saddle industry with additional burdens for the benefit of an already preferred

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. George G. Reinle of Oakland is the chairman, and Dr. George H. Kress is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. George H. Kress, Room 2004, Four Fifty Sutter Street, San Francisco.

* An editorial reprinted from *America's Future.*

‡ From an editorial in the Los Angeles *Times,* July 27, 1939.

class and levying a pay-roll tax that would offer additional premiums for substituting machines for man power.

The premarital health test law is a wise bit of statecraft that will stop the source of much human misery and public expense within the next generation, but its benefits will develop so gradually that the law's authors will get no credit or public recognition. Some skeptics are saying that the law will be evaded by trips across the state line by brides and grooms, but our guess is that when either party finds the other is a bad health risk as a matrimonial partner, then, in a majority of these, some serious thinking will result and in a majority of cases the contemplated marriages will be called off or postponed until a course of medical treatment enables the applicant to pass the test.

Also marriages across the state line will tend to cause a certain amount of local gossip that in this case will serve a useful purpose in the public's behalf.

If by some means the social-economic debit and credit sides of this legislature's work could be scanned a generation hence, we have an idea that its combined score of accomplishments and errors of omission and commission would be higher than that of most of its predecessors.—Watts *Advertiser-Review*, June 29.

IS MEDICINE A "TRADE" OR A PROFESSION?*

The Department of Justice has appealed to the United States Circuit Court to reverse the ruling of District Justice Proctor that doctors follow a "learned profession" and the American Medical Association, therefore, is not subject to prosecution under the antitrust laws.

The Attorney-General wants the higher court to rule that the doctors follow a "trade." The offenses charged against the American Medical Association, however, are in effect the operation of a closed shop. If the Circuit Court rules as the Government wishes, the result still would be somewhat embarrassing to an Administration committed to the labor theory of the Wagner Act. If doctors do follow a "trade" and, therefore, are held subject to the antitrust laws, it would be difficult to explain why the theory does not extend to bricklayers or longshoremen.

Yet, regardless of the absurd position in which the Department of Justice has put the Administration, and also of the decisions finally reached in this case, the incident is a reminder to the American Medical Association that its interest lies in working out the problem of medical care for small-income groups. It would be more acceptable to the American Medical Association than the otherwise inevitable compulsory health insurance under political control.

"DOCTORS AND POLITICS"

The medical profession has cherished almost an egotistical pride that the vocation of medicine should not concern itself with either business or politics. Certainly the average doctor carries no high reputation of being a good business man, and the late years have demonstrated his political success—to say the least, not flattering. Despite the prestige of an intellectual background, he has displayed a naïvete in practical politics that generally strikes amazement. As a consequence in this day of growing governmental expansion he has found himself in a most vulnerable position.

This is particularly perplexing, in view of the fact that the average physician, especially in the smaller communities, exercises individual influence over the minds of the laity, exceeding that of any other profession, not excluding the clergy. Several factors contribute to this end, of which not the least is his ability to instill in the minds of his patients a confidence in his integrity and honesty.

Further, no group is so well organized as the medical profession, practically every doctor belonging to some medical society. Truly an explanation for his impotency in politics rests neither on a personal inferiority nor want of organization power.

The answer is simple: In medical terminology it might be described as "voting asthenia." Votes are the essence of political influence. Endowed by training and occupation with the attributes of leadership and, moreover, in addition, fortified with a well-knit organization through which his strength may be applied, neither the average doctor nor the organization to which he belongs realize this one fundamental fact in politics. Other minority groups are cognizant of this to a realistic degree and endeavor to achieve their political ends by an efficient mobilization of their membership to a voting unit, especially when individuals or principals that concern their welfare are presented to the various elections. As a consequence these groups command the respect, and, significantly, their favor is solicited by those who aspire to public office.

To graphically portray this fact, one has only to observe the reaction of prospective candidates in their political attitude toward trade-unionism, as compared to that manifested toward the medical profession. Witness how difficult for the medical school to obtain sufficient money even to retain its accredited standing despite the almost unanimous backing by the doctors of the state for the school.

Much ado has been raised by the doctors because of growing governmental intrusions in their practice. "The Lord helps those who help themselves." Selfishness rather than altruism is actually the guiding philosophy of the day, and the sooner the medical profession, as a class, realizes this fact and become conscious of their strength as a potent political entity the easier the path of medicine will be. So long as doctors and their organizations assume a passive *laissez-faire* attitude in the governmental affairs of their communities, their political status will continue, as the saying goes, "behind the eight ball."—*Oklahoma County Medical Society Bulletin.*

EPILEPSY: A REPORTABLE DISEASE*

With the increase of mechanization in this century, epilepsy has taken on a new significance in the social order. Before the time of the automobile the epileptic was seldom a menace to others and but infrequently injured himself. Now that everyone is an automobile driver, real or potential, the situation is vastly changed. It has become incumbent upon practitioners of medicine to protect the victim of a convulsive state from himself as well as to protect the interest of others who might be the victims of his acts.

It is an interesting phenomenon, that patients who have epilepsy will deny the presence of the disorder, even to the point of swearing falsely in an application for a driver's license. When one questions them closely as to the reason for their denying the disease in their application, they give some such reply as "mine is not epilepsy, it is stomach disorder." This is a perfectly understandable reaction because of the odium which is usually attached to the malady by uninformed persons, and the repulsiveness of the convulsive attacks when viewed by the uninitiated. One cannot but have the greatest of sympathy for these unfortunate victims; on the other hand their own safety must be safeguarded as well as that of others. . . .

The Act, recently signed by the Governor, will go into effect September 3. It will thereupon become the duty of every practicing physician to report every patient who has epilepsy to the local health officer, who will send the report to the State Department of Public Health, and it will, of course, be made available for the Motor Vehicle Department. Failure to report will constitute a misdemeanor.

* From an editorial in the San Francisco *Chronicle*, August 2, 1939.

* See also comment on page 146.

CALIFORNIA PHYSICIANS' SERVICE*†

Important Announcement

With the signing of a contract by the President of California State Employees' Association and the President of California Physicians' Service on August 14, 1939, California's five thousand professional members of California Physicians' Service have started active participation in California's voluntary plan to meet the increasing cost of medical care among people of moderate incomes. This contract provides a large group of people who may become patients to be treated in connection with the Service. The California State Employees' Association has nearly nineteen thousand members and as many possible beneficiary members of California Physicians' Service.

Before any active solicitation of individuals by the staffs of the Hospital Associations and the staff of California Physicians' Service, a flow of mail came in from state employees in all parts of the State, bearing their applications and dues for health coverage—in response to an article describing the offering in their monthly publication. Most of the sixty-six Chapters of California State Employees' Association are represented in this response, and all sixty-six Chapters will no doubt respond in still greater numbers after representatives speak directly to them. Arrangements have been made for representatives of California Physicians' Service to meet with all Chapters and to present the program in detail and to answer any questions that may arise.

In San Francisco and the Bay area, in Los Angeles County, and in Sacramento, the California State Employees' Association has the greatest number of members. San Francisco and the Bay area have ten Chapters with a total membership of 3,665. Los Angeles County has twelve Chapters with a total membership of 3,189. And Sacramento has six Chapters with a total membership of 4,660. In these three districts is about half the entire membership of the Association, and the other half is divided among the thirty-nine Chapters that are scattered throughout the whole area of California.

When a good proportion of the membership of California State Employees' Association becomes beneficiary members of California Physicians' Service, this group will form an excellent one upon which to build statistical and experience data. The geographic distribution, the variance of occupations, and the relative earnings of the members appear typical of any group of this size. The large majority of almost any group of employees with a common employer are earning less than $3,000 a year. Research indicates that over 80 per cent of the population earns under that amount, so any plan which is formed primarily to furnish a service to people of low incomes is formed to serve the majority of any cross section. California Physicians' Service has been organized to furnish medical service to people of low incomes and welcomes any group that will bring to it steady wage-earners of moderate incomes who can make the monthly payments regularly. With groups of this kind, experience spread can be accomplished.

A second purpose for which California Physicians' Service was organized was to provide a means by which the doctors might be paid for their services to people of low incomes. Medical and surgical fees have always been based on (1) the magnitude and responsibility involved in the service, and (2) the ability of the patient to pay. At the monthly rates to be paid by the beneficiary members—$2 and $2.50 per member—it is expected that California Physicians' Service will pay its professional members appropriate fees for people with incomes of $1,200 to $1,500 per year. But there is no reason why people whose incomes are higher should not protect themselves against part of their hospital and medical expenses. A beneficiary member whose income is over $3,000 will receive his hospital care the same as any other member and the same amount will be paid by California Physicians' Service to his doctor as would be paid in the case of a member earning less than $3,000. This will contribute considerably toward the total fee agreed upon by him and his doctor. The doctor will charge the patient for the difference between the fee agreed upon and the amount paid by California Physicians' Service.

Any doctor holding a certificate of professional membership may treat any patient holding a beneficiary membership. Among the state employees, beneficiary membership certificates will be of two kinds, because the master contract with California State Employees' Association allows the members to choose either the deductible or the full coverage plan—that is, either the plan for $2 a month which allows complete medical and hospital care except that the patient is to be billed for the first two calls upon the doctor in any one illness directly by the doctor, or the plan for $2.50 a month which allows complete medical care to be provided by California Physicians' Service, limited only by the rules and regulations to be sent to each professional member.

To assist Dr. Morton R. Gibbons, Sr. (Medical Director of California Physicians' Service) and Dr. E. Vincent Askey (Assistant Medical Director) in coördinating medical service rendered to the beneficiary members a number of the professional members have accepted appointments as deputy medical directors in twenty-one administrative districts of California Physicians' Service. These doctors may be called upon at any time for decisions regarding the extent of medical care to be allowed under the plan. They will advise the professional members in any interpretations of contract provisions, of the rules and regulations, and of unit values on the fee schedule.

DEPUTY MEDICAL DIRECTORS

District No. 1. (San Francisco, San Mateo, and Marin counties) W. H. Winterberg, M. D.

District No. 2. (Part of Los Angeles County). Appointment to be announced.

District No. 3. (Alameda and Contra Costa counties) Daniel Crosby, M.D.

District No. 4. (Part of Los Angeles County) Richard J. Morrison, M. D.

District No. 5. (Santa Clara and Santa Cruz counties) Fred S. Ryan, M. D.

District No. 6. (Part of Los Angeles County) Morrill L. Illsley, M .D.

District No. 7. (Lake, Mendocino, Napa, Solano, and Sonoma counties) Henry S. Rogers, M. D.

District No. 8. (Part of Los Angeles County) Calvin A. Lauer, M. D.

District No. 9. (Del Norte and Humboldt counties). Appointment to be announced.

District No. 10. (Orange County) Merrill Hollingsworth, M. D.

District No. 11. (Fresno, Inyo, Kings, Madera, Mariposa, Merced, Mono, and Tulare counties) E. R. Scarboro, M. D.

District No. 12. (San Luis Obispo, Santa Barbara, and Ventura counties) Benjamin Bakewell, M. D.

District No. 13. (Alpine, Amador, Calaveras, San Joaquin, Stanislaus, and Tuolumne counties) R. S. Chapman, M. D.

District No. 14. (Imperial and San Diego counties) Hall G. Holder, M. D.

District No. 15. (Eldorado, Nevada, Placer, Sacramento, Sierra, Sutter, Yuba counties) Robert A. Peers, M. D.

District No. 16. (Kern County) L. A. Packard, M. D.

*Address: California Physicians' Service, 220 Montgomery Street, San Francisco. Telephone: EXbrook 3212. Manager, Mr. Allen Widenham.

† For additional C.P.S. information, see also, on page 206.

District No. 17. (Butte, Colusa, Glenn, and Yolo counties) Daniel Moulton, M. D.

District No. 18. (Riverside and San Bernardino counties) P. M. Savage, M. D.

District No. 19. (Shasta, Siskiyou, Tehama, and Trinity counties) F. L. Doane, M. D.

District No. 20. (Monterey and San Benito counties) Garth Parker, M. D.

District No. 21. (Lassen, Modoc, and Plumas counties) Fred J. Davis, Sr., M. D.

Informative Bulletins

BULLETIN I: C. P.S.

San Francisco, July 25, 1939.

To All Professional Members of California Physicians' Service:

Medical service has been furnished on monthly payment plans of many kinds, but never before on a *state-wide* scale by the medical profession of the state, with help and cooperation of a generous-spirited group outside the profession representing those who are to be served or bringing special knowledge and skills required.

It has been done successfully before in more restricted areas by an organized medical profession, and the officers of plans which have pioneered the way in Seattle and elsewhere in the Pacific Northwest have generously given us the benefit of their invaluable experience. But the fact that we are establishing for the first time a unified state-wide plan brings many problems for the solution of which experience does not exist.

Those of us who have been charged with initial responsibility have no illusion that we have found in advance all the answers. Fortunately we are not "writing a bill" to be frozen into law. Provision has been made so that the methods of operation as at first established may be changed when and as experience dictates.

Your trustees have foremost in mind some fundamental considerations:

1. *Coöperation.*—Success depends upon *coöperation by all* of us. There must be close and constant contact between the business offices, the medical directors, and the practicing physicians. Frequent informative letters will be sent to professional members. This is the first of such letters. To save mail expense they will be sent whenever possible with other material forwarded in the course of business. This communication is accompanying membership certificates, thereby saving $150 in postage alone.

Doubtless, hundreds of inquiries will be received about specific points. In so far as possible, may we, without offending the inquirers by our apparent impersonality and to minimize expense, assemble and answer such inquiries by general letters so that everyone may have the information?

2. *Paper Work.*—Your trustees will try to keep "paper work" down to a minimum and make it simple. In order to make the constant actuarial studies absolutely necessary for safe and fair operation of the plan some reports are necessary. It will probably surprise all of us to find how different our experience proves to be with beneficiary members of different occupation, age and sex groups, those who are single or married, who have or do not have children, who live in city, town, or country, etc. Please be assured that information requested on report forms is for such definite purposes and when collected and translated into group experience will almost certainly directly affect the future value of the "unit" of compensation paid for the work we do.

3. *Safety.*—We will have no tax funds upon which to call to make up deficits. This plan will serve well neither us, our patients nor the state generally unless it fairly pays its way. All experience now available indicates that those beneficiary members who are in groups (employed or otherwise) can be served most safely and with least administrative cost. We shall at first, therefore, accept beneficiary members only in groups. (We believe we can safely accept groups of five individuals or more, provided all the members of the smaller groups come into the plan. As the size of the groups increases, it will not be necessary to require that as many as 100 per cent become beneficiary members.) When we have a large group membership with the organization running smoothly and "overhead" well down, we can and should then accept a reasonable number of families of members and of unattached individuals and find, from experience, what it costs to serve them—information apparently nowhere available at this time.

4. *Economy of Operation.*—Money spent for "overhead" cannot be paid out for services to our patients. Administration costs will necessarily be relatively high during organization and until a very considerable number of beneficiary members are making monthly contribution. During the early months of operation, this will almost certainly make the value of the unit lower than we should like to see it. Eventually we believe "overhead" can be brought down to a very low percentage of monthly payments received.

STATE OF AFFAIRS

To date 4,978 physicians are enrolled as professional members. They are distributed in every county in the state (except two where there are no physicians practicing). This is overwhelming evidence that California Physicians' Service has the support of the profession.

1. *List of Professional Members.*—The list is printed, with names arranged alphabetically and by counties and without addresses, telephone numbers or type of practice. The list is not intended to be an advertisement. It is expected that patients will select their physicians as they do now and, having selected a doctor, refer to the list to see that he is a professional member of California Physicians' Service. The list will be mailed to you shortly, with forms and directions concerning their use.

2. *Contracts.*—Forms of beneficiary members' contracts have been drawn, studied, modified and remodified. What we hope are final forms for beginning operations have been printed and are now ready for use.

3. *Hospital Service.*—Hospitalization will be furnished as contemplated by the Insurance Association of Approved Hospitals, Intercoast Hospitalization Insurance Association, and Associated Hospital Service of Southern California. Groups of beneficiary members may now obtain protection against medical and hospital costs on a uniform state-wide basis. Definite amount of each member's monthly payment will go to the hospital associations for this purpose (this amount subject to adjustment based on experience). The remainder of the member's monthly payment will go to California Physicians' Service for professional services and administration.

4. *Fee Schedule.*—The fee schedule for professional services is intended to serve as a scale of *relative values* of various services and is *not a statement of the dollar value of any service.* It is set up in "units." One unit represents the value of one ordinary "repeat" office visit, whatever the value of an office visit may be at any time, under any circumstances. If a particular service is given a value of twenty units, that service is regarded as worth twenty times as much as an office visit.

A tentative fee schedule has been formally adopted. It is apparent that no fee schedule of relative values could possibly be established which will meet with the unanimous approval of the professional members. Your trustees earnestly beg the tolerance of the members. Please remember again that the fee schedule is subject to prompt change. It will be altered as experience proves desirable. Eventually, by experience, conference and negotiation among ourselves, we can arrive at a schedule which will be workable and fair.

The fee schedule has been approved by the trustees and will be reproduced shortly in sufficient copies so that copies will be in the hands of the deputy medical directors for reference in each community. It is not proposed to immediately distribute it generally, due to the probable necessity of revision and the difficulty and expense of maintaining revisions.

5. *Report Forms.*—All forms necessary for operation have been drafted, discussed with the actuary and accountant, and are now being printed. The necessary forms will be placed in your hands ahead of need. A beneficiary member appearing for treatment will have a form which will identify him as a California Physicians' Service beneficiary member. Detailed directions concerning your use of this and other forms will be found in the Rules and Regulations which you will receive shortly. Every effort is being made to limit necessary paper work to the minimum. Your careful coöperation in handling the report forms will pay a real dividend in the smooth operation of the plan to the advantage of all of us.

6. *Rules and Regulations.*—"Rules" for operation of the plan have been adopted in initial form. For convenience they will be printed in connection with the forms referred to above.

7. *Districts.*—The state has been divided into twenty administrative districts (subject to revision later if need be) and steps are now being taken to effect the appointment of deputy medical directors and to organize districts so that professional members may elect a permanent administrative group in October.

8. *Rates.*—For information of the members, the initial rates have been set at $2.50 per person per month for medical, surgical, and hospital service for "full coverage," or $2 per person per month if the beneficiary member elects to pay for the first two visits (office, home, or hospital) required for any one sickness or injury.

Your trustees beg that you will coöperate and be patient under the goad of the many petty irritations that may arise as the plan begins operation. Time will be needed to determine ways of facilitating administration and to iron out wrinkles not now apparent. There will be some five thousand of us concerned in the plan, and minor inquiries and personal objections cost as much time and money to handle as major ones do. Constructive comment will always be welcome.

TRUSTEES CALIFORNIA PHYSICIANS' SERVICE
Ray Lyman Wilbur, M. D., *President*
C. Kelly Canelo, M. D., *Vice-President*
Lowell S. Goin, M. D., *Vice-President*
Alson R. Kilgore, M. D., *Secretary-Treasurer*
T. Henshaw Kelly, M. D., *Assistant Secretary-Treasurer*
Samuel Ayres, Jr., M. D.
W. Earl Mitchell, M. A.
Glenn Myers, M. D.
Right Reverend Thomas J. O'Dwyer

* * *

BULLETIN II: C. P. S.

Subject: Election of Administrative Members

San Francisco, July 27, 1939.

To All Professional Members of California Physicians' Service:

The first annual meeting of administrative members of California Physicians' Service is set by the By-Laws for October 14, 1939. Prior to that time it is necessary that administrative members be elected from each district to serve the terms provided in the By-Laws. Two administrative members are to be elected from each administrative district. Districts, by counties, are outlined below:

District No. 1. San Francisco, San Mateo, and Marin counties.
District No. 2. Los Angeles.
District No. 3. Alameda and Contra Costa counties.
District No. 4. Los Angeles.
District No. 5. Santa Clara and Santa Cruz counties.
District No. 6. Los Angeles.
District No. 7. Mendocino, Sonoma, Lake, Napa, and Solano counties.
District No. 8. Los Angeles.
District No. 9. Humboldt and Del Norte counties.
District No. 10. Orange County.
District No. 11. Fresno, Merced, Mariposa, Mono, Inyo, Madera, Kings, and Tulare counties.
District No. 12. San Luis Obispo, Santa Barbara, and Ventura counties.
District No. 13. San Joaquin, Amador, Alpine, Stanislaus, Calaveras, and Tuolumne counties.
District No. 14. San Diego and Imperial counties.
District No. 15. Sacramento, Sutter, Yuba, Sierra, Nevada, Placer, and Eldorado counties.
District No. 16. Kern County.
District No. 17. Glenn, Butte, Colusa and Yolo counties.
District No. 18. Riverside and San Bernardino counties.
District No. 19. Siskiyou, Trinity, Shasta, and Tehama counties.
District No. 20. San Benito and Monterey counties.
District No. 21. Modoc, Lassen, and Plumas counties.

(Note: Los Angeles County is divided into four districts. For boundaries consult Los Angeles office, 448 South Hill Street.)

The procedure of election will be, first, nomination, and then election by mail ballot. Nominations may be made in writing by any five professional members within a district. These nominations should be forwarded to the office of the secretary of the corporation, 220 Montgomery Street, San Francisco, not later than August 20, 1939.

After nominations have been made in this way, a mail ballot will be prepared and sent to all professional members.

ALSON R. KILGORE, M. D.,
Secretary-Treasurer.

* * *

California State Employees Get California Physicians' Service †

The California State Employees' Association, which has 19,000 members, and the California Physicians' Service last night formally signed a contract by which hospital service will be provided for a fee of $2.50 a month each.

The plan is supported by 5,000 physicians practicing in every county of the state, and hospital care will be provided through the Associated Hospital Service of Southern California, the Insurance Association of Approved Hospitals of the San Francisco Bay District. and the Intercoast Hospitalization Insurance Association covering the central valley.

Employee groups whose members receive an annual family income of $3,000 or less are eligible to participate in the program.—San Francisco *Chronicle,* August 15.

CALIFORNIA LEGISLATURE: SESSION OF 1939

Report on Proposed Laws Having Relation to the Public Health and Medical Practice *

Board of Health

A. B. 1215, by Rosenthal, by request (referred to Committee on Public Health and Quarantine). Places Director of Public Health in charge of Department and gives him all of duties of State Board of Public Health.

A. B. 1216, by Rosenthal, by request (referred to Committee on Public Health and Quarantine). Establishes State Board of Public Health to act solely in advisory capacity. Fixes salary of Director at $10,000 per year.

A. B. 2107, by Dills (referred to Committee on Governmental Efficiency and Economy). Identical with A. B. 1215.

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† See also, press item on page 198.

* This report submitted by the Public Health League of California, Ben Read, Secretary. For editorial comment, see page 145. Other comment, on page 199.

A. B. 2108, by Dills (referred to Committee on Governmental Efficiency and Economy). Identical with A. B. 1216.

S. B. 1054, by Kenny and Shelley (referred to Committee on Public Health and Quarantine). Identical with A. B. 1215.

S. B. 1055, by Kenny and Shelley (referred to Committee on Public Health and Quarantine). Identical with A. B. 1216.

All of the above were killed in committee.

S. B. 1044, by Nielsen (referred to Committee on Public Health and Quarantine). Requires health officers to report epilepsy.

Passed the Legislature and signed by the Governor.

Chiropody

S. B. 1083, by Jesperson (referred to Committee on Public Health and Quarantine). Requires one year of prechiropodical work of college grade.

Passed the Legislature and signed by the Governor.

S. B. 1084, by Jesperson (referred to Committee on Public Health and Quarantine). Relates to advertising.

Died in committee.

Chiropractors

A. B. 2176, by Reaves (referred to Committee on State Colleges). Relates to courses of instruction at Fresno State College, provides for instruction in advanced chiropractic and in school nursing, and makes an appropriation.

A. B. 2177, by Reaves (referred to Committee on Insurance). Amends Compensation Act to provide employee entitled to select without restraint anyone licensed to treat in any manner the type of injury which he has sustained.

Above bills killed in committee.

Codes

S. B. 657, 658, and 659, by Mixter and Foley (referred to Committee on Public Health and Quarantine). Establishes a Health and Safety Code.

Passed the Legislature and signed by the Governor.

Compensation Act

A. B. 958, by Tenney (referred to Committee on Insurance). Amends Compensation Act. Relates to inspection of medical records.

A. B. 1520, by Atkinson (referred to Committee on Insurance). Relates to inspection of x-ray films, reports, hospital and doctors' records, clinical laboratory and other tests.

A. B. 1727, by Pelletier (referred to Committee on Judiciary General). Relates to inspection of hospital records.

All of the above were killed in committee.

Dentistry

A. B. 1708, by Johnson (referred to Committee on Education). Relates to absence of pupils from school for dental services.

A. B. 1766, by Cronin (referred to Committee on Medical and Dental Laws). Relates to applicants for licenses to practice dentistry.

A. B. 1826, by Hugh M. Burns and Cronin (referred to Committee on Medical and Dental Laws). Relates to registration of dentists and dental hygienists.

A. B. 2189, by Cronin (referred to Committee on Medical and Dental Laws). Relates to qualifications for practice of dentistry.

All of the above passed the Legislature and were signed by the Governor.

S. B. 989 and S. B. 990, by Carter (referred to Committee on Public Health and Quarantine). Relates to Dental Corporation of California, its organization, membership, government and powers, the practice of dentistry and dental hygiene.

Died in committee.

Dispensing Opticians

A. B. 516, by Cronin (referred to Committee on Medical and Dental Laws). Places dispensing opticians under license and regulation of State Board of Medical Examiners.

Passed the Legislature and signed by the Governor.

A. B. 1666, by Sawallisch (referred to Committee on Medical and Dental Laws). Places persons engaged in and training for the vocation of optical dispensing under control of the State Board of Optometry.

Killed in committee.

Health and Hospital Insurance

A. B. 610, by Kepple (referred to Committee on Judiciary Codes). Relates to hospitals eligible to enter into contracts under nonprofit hospital service plans.

Passed the Legislature and signed by the Governor.

A. B. 1573, by Hugh M. Burns (referred to Committee on County Government). Relates to care and treatment at county expense of persons requiring the same.

Died in committee.

A. B. 1712, by Johnson (referred to Committee on Insurance). Relates to nonprofit hospital service plans.

Passed the Legislature and signed by the Governor.

A. B. 2103, by Desmond (referred to Committee on Insurance). Authorizes governing bodies of counties, school districts, municipal corporations, political subdivisions, public corporations and other public agencies of the State of California to adopt a system of group life, health and accident insurance and health services for the benefit of officers and employees and to deduct from the compensation thereof the premiums upon such insurance.

S. B. 1171, by Nielsen (referred to Committee on Governmental Efficiency). Authorizes the State Controller to make rules and regulations governing pay roll deductions under plans of group insurance and/or medical or hospital services, or both, approved by the Director of Finance, and to be furnished to officers and employees of the State of California.

Above bills passed the Legislature and were signed by the Governor.

A. B. 2172, by Rosenthal, Atkinson, Dills, Gilmore, Cassidy, Kilpatrick, King, Del Mutolo, Collins, Hawkins, Gilbert, Gallagher, O'Day, Richie and Voigt (referred to Committee on Unemployment). Provides a system of health insurance within the system of unemployment reserves.

Defeated on Floor of Assembly

S. B. 1128, by Kenny and Shelley (referred to Committee for Social Security, Pensions and Relief). Identical with A. B. 2172.

Died in committee.

A. B. 2494, by Garland (referred to Committee on Insurance). Provides for regulation of insurance against the need for medical and hospital service.

A. B. 2501, by Garland (referred to Committee on Insurance). Companion measure to A. B. 2494.

S. B. 548, by Hollister (referred to Committee on Insurance). Relates to nonprofit hospital and health service plans.

S. B. 551, by Hollister (referred to Committee on Labor and Capital). Amends Labor Code to provide Statewide system of health insurance.

Above bills were killed in committee.

Hospitals

A. B. 2499, by Garland (referred to Committee on Social Service and Welfare). County Hospital Bill.

Died in committee.

Health Officers

A. B. 444, by Evans (referred to Committee on Public Health and Quarantine). Relates to city and county health officers.

A. B. 2367, by Hugh M. Burns (referred to Committee on County Government). Relates to powers and duties of county health officers.

Above bills passed the Legislature and were signed by the Governor.

Insane

S. B. 219, by Kenny (referred to Committee on Social Security, Pensions and Relief). Relates to persons mentally ill.

S. B. 526, by Kenny (referred to Committee on Hospitals and Asylums). Relates to private institutions for mentally ill or deranged persons.

Passed the Legislature and signed by the Governor.

Narcotics

A. B. 2606, by O'Day (referred to Committee on Medical and Dental Laws). Amends the Health and Safety Code relating to prescription of narcotics and dangerous drugs.

Passed the Legislature and signed by the Governor.

Naturopathy

A. B. 1203, by Voigt, Gilbert, Pelletier, Reaves and Richie (referred to Committee on Medical and Dental Laws). Regulates the persons engaged in and training for the practice of naturopathy and the schools instructing persons ton engage therein.

Died in committee.

Nursing

A. B. 563, by Fulcher (referred to Committee on Medical and Dental Laws). Practical Nursing Act.

A. B. 564, by Fulcher (referred to Committee on Governmental Efficiency and Economy). Relates to the Board of Practical Nurse Examiners.

Died in committee.

A. B. 619, by Cronin, Hugh M. Burns, Poulson, Meehan, Field, Call, Robertson, Sawallisch, Allen, Redwine, Daley and Eleanor Miller (referred to Committee on Medical and Dental Laws). Establishes Board of Nurse Examiners.

A. B. 620, by same authors as A. B. 619 (referred to Committee on Medical and Dental Laws). Nursing Practice Act.

Passed the Legislature and signed by the Governor.

Optometry

A. B. 1720, by Redwine (referred to Committee on Medical and Dental Laws). Extends rights of registered optometrists.

Killed in committee.

Osteopathy

A. B. 2346, by Daley (referred to Committee on Education). Relates to health and development certificates.

Died in committee.

Premarital and Prenatal Examinations

S. B. 173, by Fletcher, Biggar, and Kenny (referred to Committee on Public Health and Quarantine). An act to provide for the protection of unborn children and the public health by providing for premarital examinations for syphilis and providing penalties for violations of the provisions thereof and providing an appropriation for the administration of this act.

S. B. 329, by Fletcher (referred to Committee on Public Health and Quarantine). An act relating to vital statistics and making an appropriation therefor.

A. B. 493, by Hugh M. Burns, Garland, Corwin, Kepple, Dilworth, Kilpatrick, Redwine, Knight, Heisinger, Miss Miller, and Mrs. Daley (referred to Committee on Medical and Dental Laws). An act providing for the protection of unborn children and the public health by requiring examinations of pregnant or recently delivered women for syphilis, providing penalties for the violation of the provisions thereof, and providing an appropriation for the administration of the act.

Above bills passed by the Legislature and signed by the Governor.

Public Medical Care

A. B. 1874, by Del Mutolo (referred to Committee on Medical and Dental Laws). An act to promote the public health by providing for public medical care, including medical, dental, nursing, hospital, pharmaceutical and therapeutic appliance care for needy persons; providing for the opportionment of the cost of such medical care between the State and the counties and providing for the administration and enforcement thereof.

Died in committee.

Sales Tax

Assembly Bills 10 and 11, by Rosenthal (referred to Committee on Ways and Means). Exempts medicines.

Assembly Bills 33 and 34, by Houser (referred to Committee on Revenue and Taxation). Exempts medicines.

Assembly Bills 235 and 236, by Redwine (referred to Committee on Revenue and Taxation). Exempts orthopedic supplies.

Above bills died in committee.

X-Ray

S. B. 1183, by Carter (referred to Committee on Public Health and Quarantine). An act to safeguard the public health, to regulate the use of x-ray and x-ray appliances in connection with the examination of the jaws, teeth, alveolar process, gums and the immediate adjacent structures of living human beings, as an aid to the diagnosis and treatment of diseases and lesions pertaining thereto, to regulate the use, ownership and possession of x-ray appliances for said purposes; providing for the licensing of persons operating dental x-ray laboratories and x-ray appliances and setting up qualifications for such use.

Died in committee.

Miscellaneous

A. B. 1815, by Robertson. An act relating to the physical examination of the emergency hospital and medical care for students enrolled in the State colleges.

Passed by the Legislature. Vetoed by the Governor.

A. B. 2436, by Call. An act relating to scientific and surgical equipment.

Passed by the Legislature and signed by the Governor.

A. B. 2585 and A. B. 2586, by Allen, by request. An act relating to regulation and government of those engaged in the practice of massage and electrophysio-hydrotherapy.

Killed in committee.

A. B. 2795, by Donnelly. An act relating to the regulation and production and distribution of serums, vaccines, bacterial cultures and viruses.

Passed by the Legislature and signed by the Governor.

Medical Practice Act

A. B. 437, by Doyle (referred to Committee on Medical and Dental Laws). Relates to signs and advertisements in connection with the practice of medicine.

Passed the Assembly and Senate. Vetoed by the Governor.

A. B. 438, by Doyle (referred to Committee on Medical and Dental Laws). Relates to disciplinary proceedings within the chapter on medicine.

Passed the Assembly. Killed in Senate committee.

A. B. 449, by Gannon (referred to Committee on Medical and Dental Laws). Relates to citizenship of applicants to practice medicine.

Passed the Assembly and Senate. Vetoed by the Governor.

A. B. 468, by Cronin (referred to Committee on Medical and Dental Laws). Relates to the practice of medicine and surgery by graduate students and internes.

Passed the Assembly and Senate and signed by the Governor.

A. B. 469, by Cronin (referred to Committee on Medical and Dental Laws). Relates to false and untrue statements by licensed persons.

Passed the Assembly and Senate and signed by the Governor.

A. B. 470, by Cronin (referred to Committee on Medical and Dental Laws). Relates to peace officers.

Passed the Assembly and Senate and signed by the Governor.

A. B. 447, by Massion (referred to Committee on Medical and Dental Laws). Relates to unprofessional conduct in the practice of medicine and use of title "Doctor" or "Dr."

Passed the Assembly and Senate and signed by the Governor.

A. B. 478, by Johnson (referred to Committee on Medical and Dental Laws). Relates to the scope of practice of medicine and surgery permitted under a drugless practitioner's certificate.

Passed the Assembly and Senate. Vetoed by the Governor.

A. B. 484, by Kepple (referred to Committee on Medical and Dental Laws). Relates to remedies for the enforcement of the chapter on medicine. Injunction may be granted.

Died in the Assembly.

A. B. 496, by Massion (referred to Committee on Medical and Dental Laws). Relates to the use of the term "drugless practitioner."

Passed the Assembly and Senate and signed by the Governor.

A. B. 511, by Johnson (referred to Committee on Education). Relates to colleges and seminaries of learning.

Passed the Assembly and Senate and signed by the Governor.

A. B. 1505, by Gannon (referred to Committee on Medical and Dental Laws). Relates to unprofessional conduct.

Passed the Assembly and Senate. Vetoed by the Governor.

A. B. 2315, by Gilmore (referred to Committee on Medical and Dental Laws). Relates to the raising of educational qualifications of the drugless practitioner.

Passed the Assembly and Senate and signed by the Governor.

A. B. 2745, by Johnson, by request (referred to Committee on Medical and Dental Laws). Relates to a review of disciplinary action of the Board of Medical Examiners.

Died in Assembly committee.

S. B. 234, by Quinn (referred to Committee on Public Health and Quarantine). Relates to graduates of Canadian medical schools.

Passed the Senate and Assembly and signed by the Governor.

S. B. 913, by Hollister (referred to Committee on Judiciary). Relates to sale of degrees, certificates and transcripts connected with the treatment of the sick or afflicted.

Passed the Senate and Assembly and signed by the Governor.

S. B. 1182, by Carter (referred to Committee on Governmental Efficiency). Adds to Business and Professions Code, relating to judicial review.

Died in Senate committee.

COUNTY SOCIETIES

PLACER COUNTY

The Placer County Medical Society held a luncheon meeting at the Tahoe Tavern, Lake Tahoe, on July 29, with President William M. Miller presiding. Thirty-one members and visitors were present, among them being the following guests: Dr. Charles A. Dukes, President of the California Medical Association; Dr. George G. Reinle, past president of the California Medical Association and past vice-president of the American Medical Association, both of Oakland; Dr. George H. Kress of San Francisco, past president of the California Medical Association, and now the Association Secretary, and editor of CALIFORNIA AND WESTERN MEDICINE; Dr. Frank MacDonald of Sacramento, Councilor for the Eighth District; Dr. C. V. Thompson of Lodi; the Honorable Jerrold L. Seawell of

Roseville, Senator from the Seventh District; and the Honorable Allen G. Thurman of Colfax, Assemblyman from the Sixth District.

After a very delightful luncheon, served amid some of the most beautiful surroundings to be found anywhere in western North America, President Miller introduced Senator Seawell, President pro tem of the California State Senate, who, in his address, stated that, in ten years' experience in the Legislature, he had noted that things for which the doctors stood were in the interest of public health, and those measures they were against were bills which threatened to lower the standards of medicine or to jeopardize the health of the public. In his opinion, therefore, members of the medical profession were most unselfish in their efforts to influence legislation.

Assemblyman Allen G. Thurman was then called upon and gave a résumé of some of the bills affecting the profession and the public health which came before the Assembly. It was very evident that both of these men have their feet well on the ground and are for sane and safe legislation when such legislation affects in any way the health of the public.

The President then called upon Dr. Frank MacDonald of Sacramento, the newly elected councilor for the Eighth District, who made a short address in which, among other things, he assured the members of the Society that he will be ready at all times to be of assistance when called upon, and will represent their interests before the Council to the best of his conscience and ability.

Dr. Charles A. Dukes, who brought to the Placer County Medical Society greetings from the California Medical Association and its officers, then spoke of *The Objectives of the California Medical Association*; and among other things, he discussed:

The willingness of Organized Medicine to take care of everyone, irrespective of his financial situation;

The efforts of Organized Medicine to raise the standards of practice, and to maintain those standards at the highest level; and the

Budgeting of cost in medical care. Under this heading Doctor Dukes analyzed compulsory health insurance and voluntary health insurance, as exemplified by the California Physicians' Service, and a combination of voluntary insurance and governmental subsidy for the extremely low-income group.

Dr. George G. Reinle, Chairman of the Committee on Public Relations, spoke on *Medical Defense*. He dwelt upon the underlying causes of the increase in malpractice suits, naming in detail six of the principal reasons. Doctor Reinle also discussed the Oregon State Medical Society's plan and the so-called New Haven plan. He pointed out that California physicians paid the highest premium rate of any in America, with the exception of the medical profession of Massachusetts. He showed how one insurance company after another had dropped out, until today there is really only one American company operating throughout California, and this with only limited coverage. He then discussed Lloyd's of London and the "broad policy" issued in California. Doctor Reinle next took up the work of the Medical Society of the State of California, summarizing the history of malpractice protection, first by the California Medical Association and later by the Medical Society, and pointed out the desirability of membership in this society.

Dr. George H. Kress spoke on *Secretarial Problems*, discussing, among other things, the legislation brought before the recent legislature, and the legislation which will appear either on the ballot or at future sessions of the legislature. Of recent proposed acts and their results, Doctor Kress stressed:

1. The battle against the bill which would have meant compulsory health insurance;

2. The fight to prevent the passage of the bill to abolish the existing set-up of the Board in the State Department of Public Health;

3. The Citizenship Bill, which would have required an applicant for examination in medicine in California to be a citizen of the United States—a bill passed, but vetoed by the Governor; and

4. Measures regarding prenatal and premarital tests for syphilis.

Doctor Kress also mentioned the special election which is called for the purpose of deciding on the so-called "Ham and Eggs" bill, and stated that the chiropractic initiative would appear on the same ballot. He next discussed the Basic Science Law, which will in all probability be on the 1940 ballot. The Wagner Senate Bill and the Wagner Amendments to H. R. 6635 were thoroughly canvassed, and members were urged to write to their representatives in Congress expressing their disapproval of these measures. Finally, Doctor Kress referred to the press releases which are being sent to newspapers throughout California, in order that the editors may have authoritative information on organized medicine and public health. Doctor Kress also discussed *Postgraduate Conferences, the Woman's Auxiliary*, and *California and Western Medicine*, and ended with a plea to make use of the Association's central office whenever necessary.

At the close of the formal program, Doctor Miller, on behalf of the Society, expressed the members' appreciation for the excellent and informative talks by the State officers, and by our legislative representatives. Then followed a number of questions from the floor, which were promptly answered by Doctors Dukes, Reinle, and Kress.

The application of Dr. Monica Stoy Briner, for membership in the Placer County Medical Society was read and, on motion duly made and seconded, Doctor Briner was unanimously elected.

The Secretary then brought up for consideration the names of two of our Placer County Medical Society's oldest members who have retired from practice. A motion was made, seconded and carried, that the Secretary direct a letter to the Council asking for retired membership for these two members.

The Secretary stated that 50 per cent of the members had paid the special assessment, and urged prompt payment by those who have not already made remittance.

The Secretary also urged our members to write their representatives in Congress regarding the Wagner amendments to H. R. 6635.

By order of the members of the Society, President Miller instructed the Secretary to write to Mr. Ward, Manager of the Tahoe Tavern, and thank him for the excellent luncheon and the Tavern's good service.

There being no further business, the meeting adjourned.

ROBERT A. PEERS, *Secretary.*

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SACRAMENTO COUNTY

The regular meeting of the Sacramento Society for Medical Improvement was called to order by President Manuel L. Azevedo at the Auditorium on Twenty-ninth and L streets, on May 16.

There were forty-eight members and guests present.

The paper of the evening was presented by Dr. F. F. Gundrum of Sacramento. His subject was *Regional Ileitis*. Doctor Gundrum first discussed the history of the disease, then the pathology, incidence, etiology, and treatment. Doctor Saeltzer reported on a patient he had recently operated upon. Doctor Titus, likewise, reported one of his cases which seemed to fall under this classification. Doctor Gundrum's paper was well given, and elicited much discussion by Doctors Reardan, O. Cook, and Pulford.

Dr. Raymond Wallerius introduced a motion regarding the Sacramento Pharmacists' Guild, which was passed. Doctor Wallerius also reported on the California Medical Association Convention at Del Monte.

GLENN E. MILLAR, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (38)

Alameda County

Lloyd F. Hawkinson
Rufus I. Newell
William F. Priestly
Alfred Stern
Philip R. Van Horn

Humboldt County

Howard W. Finke

Imperial County

Claude F. Peters

Inyo-Mono County

Selda E. Anthony
Lloyd S. Bambauer
Harvey W. Crook
James Lloyd Mason
William M. Russell
Clarence L. Scott
Riley Shrum
George D. Shultz
William I. Shultz
N. John Zahry

Kern County

W. L. McEwen

Los Angeles County

John C. Arnout
Eddie Henry Lager
Joseph Leo Maeth
Charles Mandel
Armas Manning
Sidney Messer
Frederick Leo Pickoff
Byron L. Stewart
Fessenden O. Westfall
Ross G. White

Monterey County

Clark Saunders
E. E. Wadsworth

San Bernardino County

William L. Cover
Joel M. Gibbons

San Diego County

Raymond C. Lindholm

San Francisco County

R. Emmet Allen

San Mateo County

Logan Gray

Santa Barbara County

L. C. Newton Wayland

Sonoma County

A. G. Maximov
G. E. Webster

Transferred (1)

John Blum, from Santa Clara County to Alameda County.

In Memoriam

Boyd, Truman Osborne. Died at Long Beach, July 8, 1939, age 70. Graduate of the University of Louisville School of Medicine, 1902. Licensed in California in 1904. Doctor Truman was a retired member of the Los Angeles County Medical Association.

✝

Clark, Isaac Sherman. Died at Spokane, Washington, August 3, 1939, age 69. Graduate of Keokuk Medical College, Iowa, 1898. Licensed in California in 1921. Doctor Clark was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✝

Hodges, Walter Allen. Died at La Vina, July 22, 1939, age 58. Graduate of St. Louis University School of Medicine, 1905. Licensed in California in 1930. Doctor Hodges was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Hughes, Ephraim George. Died at Long Beach, July 7, 1939, age 60. Graduate of Jefferson Medical College of Philadelphia, 1907. Licensed in California in 1927. Doctor Hughes was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✝

Leonard, Alexander Thomas. Died at San Francisco. July 2, 1939, age 81. Graduate of the Royal College of Physicians and the Royal College of Surgeons, Edinburgh, Scotland, 1882. Licensed in California in 1884. Doctor Leonard was a retired member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

✝

Lobingier, Andrew Stewart. Died at Los Angeles, July 31, 1939, age 77. Graduate of the University of Michigan Medical School, Ann Arbor, 1889. Licensed in California in 1901. Doctor Lobingier was an honorary member of the Los Angeles County Medical Association.

✝

McLellan, George Hudson. Died at San Diego, July 14, 1939, age 55. Graduate of the University of Michigan Medical School, Ann Arbor, 1907. Licensed in California in 1922. Doctor McLellan was a retired member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Rees, R. Bynon. Died at Los Angeles, August 21, 1939, age 71. Graduate of University of Maryland School of Medicine, and College of Physicians and Surgeons, Baltimore, 1900. Licensed in California in 1906. Doctor Rees was a member of the Kern County Medical Society, the California Medical Association, and the American Medical Association.

✝

Tobias, Elliott Benald. Died at San Francisco, August 2, 1939, age 40. Graduate of the College of Physicians and Surgeons, San Francisco, 1921, and licensed in California the same year. Doctor Tobias was a member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

✝

Updegraff, Thaddeus S. Died at Pasadena, August 2, 1939, age 74. Graduate of Jefferson Medical College of Philadelphia, 1883. Licensed in California in 1893. Doctor Updegraff was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

OBITUARIES

Alexander Thomas Leonard

1858–1939

Few of us expect to be engaged in our profession at the age of eighty, but one who was, and who lived his life fully and energetically to the end, was Dr. Alexander Thomas Leonard, a pioneer connected with the early history of our city. On July 2, Doctor Leonard passed away after a long and interesting life. Born in County Galway, Ireland, September 11, 1858, he received his education at the Royal College of Surgeons and Queen's College, Ireland, and

the Royal College of Surgeons at Edinburgh, winning the Sir Charles Bell Medal in 1883. . . .

Many of the older residents of the city remember Doctor Leonard in the "horse and buggy days," for he was one of the last to give up the horses that he loved so well. One by one, however, they were put out to pasture and, finally, the old buggy, with its hunting dog running beneath, was supplanted by a modern car. In 1917 Doctor Leonard became director and staff surgeon of Trinity Hospital, and director of the Nurses' Training School. . . .

Friends and patients filled the church and overflowed into the street outside, for there was not room for all of them. So passed another well-loved man of medicine, and one more link with the olden days is gone.

H. M. F. BEHNEMAN, M. D.

✠

H. D'Arcy Power

1856–1939

Those of the older physicians and surgeons of San Francisco who once knew Dr. H. D'Arcy Power will learn with profound regret of his passing away at Berkhampstead, a suburb of London, on July 25, 1939, at the age of eighty-two years and four months.

For many years he was a prominent clinician in the Bay city and an influential member of both the California Medical and the American Medical Association. He enjoyed distinction as dean of the College of Physicians until its destruction by the earthquake and fire in 1906, and six years later he was editor of the California Medical Association journal, thereby further guiding the development of scientific and organized medicine in the West. For ten years Doctor Power lived at the mining town of Freiberg, Germany, where, as a chemist of note, he contributed to the scientific literature of various European professional periodicals. He was recognized as an authority on photography, and credited with a worth-while part in the development of color processes. With Doctor Hala of Brooklyn, New York, he wrote "Power's and Hala's Pathology," and at the time of his death had several scientific works more or less complete in manuscript.

✠

Samuel Leroy Rea

1874–1939

Dr. Samuel Leroy Rea, who died on June 8, was born in Pomo, now Potter Valley, on February 2, 1874, the son of Joseph N. and Mary J. Rea, California pioneers of 1869. From Potter the family moved to Covelo, where the lad, Samuel, attended the grammar school; and when he was ready for more advanced study he went to San Francisco and was there graduated from the Polytechnic High School. Entering the Cooper Medical College, he received his M. D. degree in 1896. After a year as intern in the City and County Hospital, he located for a year at Hopland, and then settled down to establish a more permanent practice in Ukiah, soon becoming so popular, through both his skill and nobility of character, that he came into touch with wide circles throughout the county. On December 1, 1903, Doctor Rea and Miss Stella McCormick were united in marriage, and two sons—Dr. Stanley L. and Walton Joseph—blessed their union.

Commencing his professional career in the middle nineties, Doctor Rea was privileged to contribute much toward the development of both medicine and surgery in Ukiah and Mendocino County, making innumerable trips to visit and alleviate the afflicted in distant parts when horseback, buggy, horse-stage, and the automobile were, in turn, the only forms of transportation. It has been said that one might write a bookful of his travels. He was particularly active in fathering and developing the Langland Hospital, of which he was the controlling head for years; later generously devoting the same time and energy to the expansion of the Ukiah General Hospital, where he directed the surgery. Everywhere that he went, every time that he served, he left with those coming into his life the same impressions—never to be forgotten.

"A friend of all, with a benevolent, sympathetic nature," says Dr. Raymond Babcock, in a touching tribute, "and seeking ever to attain, what he believed in, the highest professional standing. I salute our confrère, a man, if ever there was, of sterling character, and one to whom we, of this Mendocino-Lake County Medical Society, owe a great deal, particularly for bringing us through very trying times. It was my privilege, indeed, to have known this man since my boyhood, admiring him as a country doctor, enjoying with him my first automobile ride, and later, in the capacity of druggist, consulting with him in the care of the sick, when his humanity as a doctor, his professional wisdom, his ready wit, and his keenness of intellect in emergency were again and again revealed. His fame will long live, particularly in the hearts of those to whom he became a benefactor. So, as friend and associate, I salute him and bid him bon voyage on the journey to that higher career which we hope will still bring him the finest of things such as he has assuredly left behind."

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. FREDERICK N. SCATENA.....President
MRS. WILLIAM C. BOECK.....Chairman on Publicity
MRS. KARL O. VON HAGEN..Asst. Chairman on Publicity

Report: Seventeenth Annual Session of the Woman's Auxiliary to the American Medical Association

Theme: With the permanent values of yesterday, let us build wisely and courageously today, toward a happier and more righteous tomorrow.

By MRS. FREDERICK N. SCATENA
President of the Woman's Auxiliary to the California Medical Association

To the Members of the Woman's Auxiliary to the California Medical Association:

The seventeenth annual convention of the Woman's Auxiliary to the American Medical Association was held in St. Louis, Missouri, May 15 to 19, 1939. Headquarters were situated in the Chase Hotel, where there was ample room for registration and exhibits. In the main foyer on the same floor the Auxiliary held its board and general meetings.

The official family of the organization met on Monday morning in the Regency Room of the hotel. Our National President, Mrs. Charles C. Tomlinson of Omaha, Nebraska, opened the preconvention meeting. Roll call followed the prayer, and then continued the usual routine of board meetings, announcements of committees; recommendation of officers and committee chairmen. An informal luncheon followed, where an opportunity was offered to greet old friends and meet new ones.

Tuesday morning, May 16, in the Regency Room, the formal opening of the convention took place. Mrs. Tomlinson presided. Mrs. Willard Bartlett, General Chairman,

† As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Karl O. Von Hagen, Assistant Chairman on Publicity, 5867 Whitworth Drive, Los Angeles. Brief reports of county auxiliary meetings will be welcomed by Mrs. Von Hagen and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

was introduced. Invocation by Rev. J. W. MacIvor. Then followed the address of welcome tendered by Mrs. E. Horace Johnson; the response was made by Mrs. Samuel Clark Red of Texas, nationally known as an organizer. It was Mrs. Red's inspiration of the idea which resulted in the formation of the Woman's Auxiliary, and she served as its first national president for a period of three years.

* * *

In Memoriam.—"For those who have preceded us into the mysterious land from whose bourne no traveler ever returns" was given by Mrs. Charles P. Corn. The minutes of the sixteenth annual convention, held in San Francisco, were read and approved. Roll call disclosed that thirty-seven states and the District of Columbia were represented.

Our own Mrs. Eric Larson of California was appointed chairman of the Resolutions Committee. The Committee report was read and approved.

Then followed the President's address. In this she stressed the imperative need of coöperation, the need of courage, inspiration and desire to assume responsibility. She gave high commendation to her board members for their loyalty and for the record of achievement which they were leaving.

The work under the leadership of Mrs. Tomlinson has been far-reaching and successful.

The Treasurer's report indicates the sound financial status of our organization, the budget has not been exceeded and there is a substantial balance on hand. The annual budget for 1939-1940 has been increased.

Organization report of Mrs. Frank Haggard: This report revealed the fact that, while most states showed an increase in membership, California showed the greatest percentage of decrease.

* * *

Hygeia.—Mrs. Frank N. Lester reported an increase in circulation, and also suggested that a copy of *Hygeia* be given to each rural school, and that it be placed in public institutions, libraries, salons, and reading rooms of the Young Men's Christian Association and the Young Women's Christian Association.

Mrs. Lester further stressed the fact that one of the prime duties of the Auxiliary is the distribution and promotion of *Hygeia* through the Parent-Teacher Association, Boards of Education, and other bodies interested in education. The success which *Hygeia* has had may be said to be a direct outgrowth of the determined effort and will to succeed, which Mrs. Lester has shown in her campaign for *Hygeia.*

* * *

Legislation.—Mrs. Arthur Herold, Chairman: A definite educational program has been prepared for the county auxiliaries this year.

The topics for study will include: State or Socialized Medicine; Free Clinics, Uses and Abuses; Official Medical Service Bureau; The Healing Cults; Antimedical Propaganda, each having subtopics.

* * *

Publicity.—Mrs. James P. Simonds, Chairman: Progress and efficiency have characterized the work of the State Publicity Chairman. The splendid spirit of coöperation has lightened the labor and increased interest in the many forms of publicity. Many states have evolved their own organ for publicity; these are either in the form of a news letter or some type of publicity calculated to increase interest, in some instances purely local in color.

* * *

Public Relations.—Mrs. Henry Raile, Chairman, reported increase of interest in state and county auxiliaries.

The following recommendations are presented for county chairmen of public relations:

1. Study recommendations and equipment from National and State chairmen.

2. Consult the president of your county auxiliary and advisors about county work as recommended and about plans for essay contest, speakers' bureaus, radio broadcasts, press notices, health programs for and in lay organizations, coöperation with a summer round-up, selection and distribution of educational material, *Hygeia* booths at fairs, etc.

3. Have a Public Relations Committee of members having experience and membership in other organizations. Include some members who are new in the work, as it is our constant purpose to train others to succeed us in this work. Call a meeting as soon as your county plans are prepared and discuss objectives, plans, procedure, and equipment for the year and assign definite projects to each member.

4. Discuss plans with the president and chairman of your Program Committee and secure a regular time at every meeting to give facts on public relations work.

5. Ask each member to give you a list of lay organizations of which she is a member and the committees and chairmanships in them to which she belongs. Urge members to ask for places on health committees; to accept chairmanships and learn the plans of such committees; to give their presidents health information which your auxiliary is promoting; to attend the meetings where speakers on health participate and report unwise and unacceptable programs and activities; to offer a list of material; to recommend *Hygeia*; and to explain the Speakers' Bureau of your medical society to them.

6. Compile a list of city and county lay organizations with names and addresses of their presidents and health chairmen; if possible, have copies made for your members, but at least for your president and officers.

7. Have one or more county public relations programs for lay organizations in your county. Details of plans for such an event may be secured from your state chairman.

8. Have a national handbook and a subscription to the National News Letter; read the Auxiliary pages in *The Journal of the American Medical Association* and in the state journal of your medical association; be on the mailing list of your state board of health; read and contribute to your state auxiliary news; write to your state chairmen for data on their plans, as it is necessary to know all phases of Auxiliary work when engaged in public relations work.

9. Consult your advisors, president, and state chairman whenever in doubt; educate members; equip those who are assisting, and remind members that no one need to try to do more than she understands or that is convenient at a given time.

10. Suggest books and articles to read which will add to the appreciation of the medical profession and medical arts and give a foundation for public relations work.

* * *

Exhibits.—Mrs. Ily R. Beir, Chairman: The exhibits were not only attractive, but educational. All were well thought out and presented for quick assimilation for visitors whose time was limited.

The exhibits comprised scrapbooks; maps and charts, showing expansion; displays, showing the various posters; illustration or displays, showing the various activities of the state or counties, with details of one or more lines of especial progress; and some noteworthy exhibits giving a general idea of the activities of that state. California had many copies of the "Courier" on hand and great interest was manifested as members and guests looked through the pages.

The President's report on the thirty-nine states and the District of Columbia were read by authorized delegates, and will be published in the next News Letter.

Many states had problems to solve, all of an interesting nature, particularly the larger cities, where the unprecedented demand upon one's time for social, civic, religious, and club activities almost robs one of the right to live as an individual and undoubtedly reduces the effectiveness of Auxiliary activity.

The present task and ambition is to maintain and further the principles upon which our organization has been built. No organization, no matter how lofty its ideals or how fervent its members, can endure without a well-balanced and sincere belief in its members.

I believe the interchange of new ideas, reports of activities, opportunity of making new friendships and renewing old ones, aid in the furthering of our common interest.

The election and installation of officers were capably handled by Mrs. J. Newton Hunsburger. Mrs. Rollo K. Packard of Chicago, Illinois, will serve for the ensuing year as president. She has the assurance of the loyalty and coöperation of the membership and their sincere wish that her year of administration will be a happy one.

"Coming together means Beginning.
Being together means Progress.
Keeping together means Success."

I wish to express my appreciation for the opportunity of attending this seventeenth annual meeting, and if I have enlightened you a particle or made your interest a bit keener, for that I am grateful.

* * *

The social program was arranged under the direction of a most capable convention chairman, Mrs. Willard Bartlett. Many diversified plans had been made for our entertainment. This provided a delightful holiday which was pleasant and instructive.

On Sunday evening, May 14, a reception for the National Board of Directors and all visiting ladies, in honor of Mrs. Charles C. Tomlinson, National President, was held at the home of Mrs. Willard Bartlett, the Board members of St. Louis Auxiliary and the Convention Chairmen assisting the hostess. Mrs. Bartlett served in the same capacity as convention chairman sixteen years ago in St. Louis, when our Woman's Auxiliary to the American Medical Association was organized.

On Monday afternoon we had the opportunity of visiting three most interesting gardens in St. Louis:

The garden of the hazelnut estate of Samuel W. Fordycis was charming. It was rich in unusual native flowers; rare iris and colorful columbine were in abundance.

The home of Joseph Dosloge, of copper fame, is one that shall always linger in my memory. The color combinations, garden composition and arrangement of flowers for interior decoration made it superb. We had the pleasure of a decided contrast in the home and garden of Dr. and Mrs. Vibray. Their home and furnishings were early American, and in the garden Nature has already done most of the work in naturalistic planting of fine old trees and shrubs. Tea was served outdoors on a veranda, where the cool breezes of the Missouri refreshed us tremendously.

The program arranged by the committee for this afternoon was enjoyed by all the garden lovers. St. Louis may well be proud of her charming hostesses.

The Auxiliary of the Southern Medical Society served as hostesses for a breakfast on Tuesday morning, May 16, honoring Mrs. Tomlinson. Their president, Mrs. Willis Kelly West, presided. Doctor McCormick, President of the Southern Medical Society, and Dr. Irvin Abell, President of the American Medical Association, gave short addresses, both agreeing, however, that the united efforts of the loyal Auxiliary members throughout our National organization will accomplish much in preserving the health of our nation.

"A word fitly spoken is like apples of gold in baskets of silver."

Tuesday noon: Luncheon was served in the beautiful St. Louis Woman's Club in honor of the past president of the Woman's Auxiliary to the American Medical Association. Our National organizer, Mrs. Samuel Clark Red, was the guest speaker, and in her charming manner she gave us a résumé of the early-day activities of the organization—in fact, it was the first time since the formation of the National, organized in 1922, that St. Louis had the honor and privilege of extending hospitality to the American Medical Association and their guests. Mrs. Red related the fact that, while the Auxiliary was organized in St. Louis in 1922, their first meeting was held in the "City of Enchantment," San Francisco, the following year, 1923. Each state was asked to send two delegates to the meeting in San Francisco. About twenty courageous women responded to her appeal. They met with confidence, ignoring the discouragements, which were many; and, believe it or not, not one Californian attended the meeting. "Happy are we met, happy have we been, happy may we part, and happy meet again."

On Tuesday afternoon a conducted tour of interesting places included the Zoölogical Gardens, Museum of Fine Arts, Lindbergh trophies, and the Hospital Group of Washington. This proved very interesting. The chartered buses brought us back to the St. Louis Medical Society building, where tea was served. Members of the Women's Club of St. Louis University School of Medicine were our hostesses and the members of the National Board were honored guests. An abundance of beautiful flowers decorated the entire building.

On Tuesday evening, at the six-million-dollar St. Louis Opera House we had the privilege of attending the opening meeting of the American Medical Association.

The president of the American Medical Association, Dr. Irvin Abell presided. After the Invocation by Rev. William Scarleett we were welcomed by the Honorable Lloyd C. Stark, Governor of Missouri, and the Honorable Bernard F. Dickmann, Mayor of St. Louis; James R. McVay, President of the Missouri State Medical Association; Alfonse McMahon, President of the St. Louis Medical Society.

Their words of welcome added greatly to the sincerity of a truly dignified program. Dr. Rock Sleyster was inducted into office as president of the American Medical Association and gave a very interesting but alarming talk on psychiatry and its effect on this generation.

A reception and inspection of exhibits in the Auditorium was of great interest to all members and visitors.

* * *

The annual luncheon on Wednesday, May 17, in the Chase Club, at which Mrs. Tomlinson presided, will always serve as a gentle reminder of the charming simplicity of our president. To her I give the fullest measure of praise and appreciation for the very fine manner in which she conducted our meetings, both business and social.

The committee in charge surrounded our president and the guest speakers with the choicest of spring blossoms, and the entire dining room was filled to capacity; many late comers could not secure luncheon tickets. Mrs. Tomlinson introduced, first, the gentleman who was responsible for making possible the time and energy she gave to the Auxiliary work this year. The credit for any achievement she might claim belonged partially to this person for the gracious understanding of the problems which confronted her on occasions and his reasoning powers which assisted her when most needful, Dr. Charles C. Tomlinson. A musical program, given by the nationally known baritone,

Robert Lawrence Pribble, added greatly to the enjoyment of a delightful luncheon.

Dr. Rock Sleyster, President of the American Medical Association, addressed the group assembled, not as Auxiliary members, but as doctors' wives, giving us much praise and asking for our continued patience and tolerance which is essential in the home life of any successful physician. A reception and inspection of exhibits followed.

On Wednesday evening the Woman's Auxiliary to the St. Louis Medical Society invited all visiting ladies to the seventeenth anniversary reception and buffet supper in honor of the Founders and the National President at the Society building.

On Thursday afternoon a Mississippi steamboat trip for the doctors and their wives was enjoyed by a large group. That evening a "bring your husband dinner" was charmingly presided over by Mrs. Willard Bartlett. The traditional reception and ball, honoring the President of the American Medical Association, added greatly to the gaiety and glamour of that memorable evening.

Friday was play day. The St. Louis Country Club sponsored golf games, presenting trophies or prizes to the winners. For those not interested in sports a tour of historic St. Louis was provided.

This concluded a most enjoyable social program.

* * *

In summarizing the entire activities of the Convention, I realize the social affairs arranged for members and guests were very well attended and enjoyed tremendously. Why have we not more interest and a larger attendance at our general sessions? Two hundred and nine men registered from California and only five women appeared at the meeting. Our meeting place was delightfully situated, and the usual procedure of a convention meeting was carried out in an intelligent and dignified manner.

It is not only a compliment to the President and the Board of Directors, who give up their time and strength that we may have the pleasure of a diversified program arranged to educate and entertain, but it is an obligation we assume when we accept an office or become a member of the organization.

They desire a larger enthusiastic attendance, and why do we not coöperate?

For the privilege of attending this meeting, I am grateful.

MRS. FREDERICK N. SCATENA.

Notice of Proposed Amendment*

Proposed amendment to Section 1 of Article 9 of the Constitution of the Woman's Auxiliary to the California Medical Association:

SECTION 1. For the years 1940 to 1941 and 1941 to 1942, the Nominating Committees, each consisting of five members, shall be appointed at the annual meeting, held in May, 1940. Each committee shall consist of five members, two of whom shall be elected by the Board of Directors, and three to be members at large, elected by the House of Delegates. The members elected by the Board of Directors shall be elected at the regular meeting held previous to the annual meeting, while the members elected by the House of Delegates shall be elected at the first session of the annual convention. The Board of Directors shall designate the chairman of each committee. The Nominating Committee so elected for 1940 to 1941 shall present its report of nominees as soon as possible. The Nominating Committee so elected for 1941 to 1942 shall meet sixty days prior to the annual meeting in 1941, and prepare its report and submit the same at the first session of the annual meeting in 1941.

Beginning with the annual meeting in 1941 and annually thereafter, the Nominating Committee shall be appointed each year in advance and shall consist of five members, two elected by the Board of Directors and three to be members at large, elected by the House of Delegates.

It shall be the duty of the Nominating Committee to nominate and present in the regular order of business, candidates for the following offices: president-elect; first vice-president; second vice-president; recording secretary; treasurer; and four councilors-at-large, to serve for one year or until their successors assume office.

* This proposed amendment was favorably acted upon at the California Medical Association Council meeting, held August 5, 1939. See also, on page 182, item 32.

Stomach and Duodenal Ulcers Must Be Considered Chronic.—Recurrences of ulcers of the stomach and duodenum never will be prevented until the disease is viewed as chronic and the victims placed under rigid medical management, as are those afflicted with diabetes or pernicious anemia, Clarence F. G. Brown, M. D., Chicago, and Ralph E. Dolkart, M. D., Boston, declare in *The Journal of the American Medical Association.*

Citing their own experience to support this recommendation, they state: "We have found that 68 per cent of the recurrences in our clinic occur during the spring and fall. By observing patients at regular intervals throughout the year and placing them under rigid medical management during these seasons as a prophylactic measure, we have reduced the incidence of recurrence by approximately 15 per cent."

Explaining the causes of recurrence among their patients, Doctors Brown and Dolkart state: "Functional nervousness, including fatigue and anxiety, was by far the greatest detectable cause of recurrence. Next in importance was an acute infection such as a cold, an acute sore throat, a sinus infection, an acutely abscessed tooth or stomach, and intestinal inflammation. Of third consideration were the things put into the stomach by the patient, hamburgers and restaurant potato salad leading the list in foods, with salicylates and iron preparations prescribed by other physicians following closely."

No single form of treatment is successful in the management of chronic ulcer, the physicians point out. The chief aim of treatment is to protect the ulcerated area from irritation, and this goal can be attained by different routes.

"The surprisingly good records made by patients treated with hourly feedings, relative reform from frantic, anxious living, and antispasmodic medication cannot be emphasized too much," they continue. "Curtailment of emotional excitement and of fatigue are as fundamental in any plan of ulcer treatment as are the medications prescribed."

They criticize treatments in which the principal object is to neutralize the secretions of the stomach. Neutralization day and night for the life span of a patient is impossible even for the most astute physician. Giving alkaline powders may even make the patient worse, and it has been alleged that kidney stones occur in such patients to a significant degree. Such treatment makes the chronic ulcer more chronic and nothing constructive is accomplished.

Certain preparations containing aluminum hydroxid have been used with less undesirable effects, but they have been no better in preventing recurrences. Treatment with mucin, a normal constituent of the secretions of the stomach, with frequent feedings and drugs to relieve the abnormal movements of the stomach, has been found more successful than any other form of medication. A recent development is the use of "vegetable mucilage," which has been effective in mild cases.

Drivers between the ages of sixteen and twenty kill on the average twice as many persons in highway accidents as is averaged by all motorists, according to statistics in the August issue of *Hygeia.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, New York, June 10–14, 1940. Olin West, M. D., Secretary, 535 North Dearborn Street, Chicago, Illinois.

California Medical Association, Hotel Del Coronado, Coronado, May 6–9, 1940. George H. Kress, M. D., Secretary, 450 Sutter Street, San Francisco.

Nevada Medical Association, Reno, September 22 and 23, 1939. Horace J. Brown, M. D., Secretary, P. O. Box 689, Reno, Nevada.

Medical Broadcasts*

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of September is as follows:

Thursday, September 7—KECA, 9:45 a. m., The Road of Health.
Saturday, September 9—KFI, 10:30 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, September 14—KECA, 9:45 a. m., The Road of Health.
Saturday, September 16—KFI, 10:30 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, September 21—KECA, 9:45 a. m., The Road of Health.
Saturday, September 23—KFI, 10:30 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, September 28—KECA, 9:45 a. m., The Road of Health.
Saturday, September 30—KFI, 10:30 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.

Friendly Government Needed, Says Connecticut Governor.—*The Commonwealth,* official publication issued each Tuesday for the Commonwealth Club of California, in its issue of August 22, 1939, gave a brief digest of comments made in a recent address before the Club, the following being quoted therefrom:

"Calling for a 'friendly government' in national affairs, Governor Raymond E. Baldwin of Connecticut, in an address to a special Tuesday meeting of the Club, pointed to the results secured in his own state: . . . 'We are losing our Statehood to the steadily increasing domination of a highly centralized, and, as in the case of you in California especially, a far-distant, government whose powers were strictly limited and clearly defined by the Constitution granted by the original States for the very purpose of checking that growth,' the Governor said.

"We in Connecticut possess a profound skepticism that you can ever get anything for nothing.

"And we are inclined, too, to respect the advice—the hard truths—left to us by our first President: 'That facility in changes upon the credit of mere hypotheses and opinion exposes to perpetual change, from the endless variety of hypotheses and opinion.'

"For eight years, we have followed 'the endless variety of hypotheses and opinion." . . .

Report Shows Medical Aid Given 24,994 Farm Workers.—An Associated Press dispatch from Fresno, dated August 27, follows: A total of $982,207 was expended by the Agricultural Workers' Health and Medical Association in California and Arizona since the governmental coöperative was established March 4, 1938. Medical and dental care was provided for 24,994 persons.

This was disclosed by Robert J. Graves of San Francisco, secretary-treasurer of the association, in a report submitted at the first annual meeting of the membership here. Graves said the association membership as of June 30 totaled 13,055 in the two states and operated on a budget of $1,082,000.

Of the $982,207 actually expended, $811,000 represented medical and dental care for migrant farm workers and the balance of $171,207 covered administrative costs, including clinics, equipment, salaries, supplies, travel, rent and utilities.

Directors of the association reëlected are Dr. Karl L. Schaupp, representing the California Medical Association; Dr. W. R. P. Clark, State Board of Health; Dr. Albert E. Larsen, medical director of S. R. A.; Jonathan Garst, regional director of F. S. A.; Ralph W. Hollenberg, assistant regional director of F.S.A.; Homer Mills, regional F.S.A. economist, and Graves, regional finance manager of F.S.A.

Since operation of the association began, 24,994 individuals have been treated in the two states, with professional services rendered by 700 physicians and 150 dentists.—Los Angeles *Times.*

Advisory Committee to the San Mateo County Tuberculosis and Health Association.—There has recently been appointed a Medical Advisory Committee to the San Mateo County Tuberculosis and Health Association, composed of Doctors Musselman, Benninghoven, Gregory. Monteith, Bridgman, Blood, Mawdsley, and Warren. It is to be expected that this committee will sit in an advisory capacity and function to some extent at least as a liaison committee between the County Medical Society and the Tuberculosis Association.

Any questions or suggestions one may have to submit in connection with tuberculin testing in the schools and other problems of tuberculosis control in San Mateo County should be referred to one of these committee members.

The following proposed program of the Association for the year 1939 and 1940 was considered and approved by the Committee.

1. All high school seniors in San Mateo County to be tuberculin tested.
2. Education of school nurses to modern methods used in tuberculin testing, diagnosis, and the care of tuberculous patients.
3. The sending of follow-up letters to the negative and positive reactors of 1937 and 1938.
4. Carrying out of a program of educational work in the schools, industries, and adult groups by the use of motion pictures, slides, literature, radio, etc.
5. Recommended the solicitation of the County Health Department for suggestions and assistance in carrying out the program.
6. It was suggested that children who are positive reactors and who require x-ray examination would be expected to pay a reduced fee for such x-ray examination where possible.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

To Help Save One Hundred Lives Between Now and New Year's Eve.—The California Safety Council, 805 Fife Building, San Francisco, and 805 Pacific Electric Railway Building, Los Angeles, is publicizing the following pedestrian safety pledge:

Sponsored by (Name of Local Organization) in Conjunction with California Safety Council

As a pedestrian I hereby subscribe to the following pledge to advance public safety in this city:

1. Refrain from crossing streets except at intersections and then only after careful observation of oncoming traffic.
2. Realize that coöperation with drivers in the matter of courtesy should be reciprocal.
3. To face oncoming traffic when walking on the highway.
4. To make safe practices a habit for my own safety.

Hidden Cases of Venereal Disease.—Current national emphasis on open discussion of venereal diseases is resulting in the discovery of vast numbers of hidden cases, officials of the United States Public Health Service recently reported.

Interviews by trained social workers of patients under treatment for venereal disease in a public health clinic bring to light an average of three new contacts for each two interviews. More than 90 per cent of the patients coöperated in telling of contacts and aided in bringing them to treatment. A syphilis rate of 40 per cent and a gonorrhea rate of 62 per cent were found for the contacts examined.

Patients with early cases of syphilis were less coöperative in divulging sources of infection than were patients with later forms of the disease. Gonorrhea contacts were five times as high outside of marriage as within families.

More than 40 per cent of the 281 contacts who were examined for syphilis were found to be infected. More than 62 per cent of the 72 contacts who were examined for gonorrhea were found to be infected.

Early Smallpox in State Stopped by Vaccination.—Long-hidden information tending to show how the California of a century and a quarter ago was saved from successive waves of smallpox through widespread vaccination, is revealed in an article by Dr. S. F. Cook, Division of Physiology, University of California Medical School, in the current *Bulletin of the History of Medicine*. The aged documents consulted by Doctor Cook reveal that the New Spain of far western America, isolated by thousands of miles from the mother country, was one of the first great areas of the world to obtain the benefits of vaccination, discovered by Jenner in 1798.

By 1803 vaccination was widely used in this great area, the vaccine being first brought in by an expedition under command of Francis Xavier de Balmis. Thereafter but few references appear either to vaccination or smallpox until 1817, and even then the situation apparently was not serious, despite the many setbacks offered by the native population in regard to accepting the benefits of the new therapy.

In 1828, however, the long regional immunity of California came to an end, and the first of a series of devastating epidemics began. Thereafter the adventurous James Ohio Pattie came forth with his startling claim that he had vaccinated 22,000 persons between San Diego and Fort Ross in Sonoma County, but this number was considerably cut down by other authorities. Much of Doctor Cook's narrative is given over to Pattie's apparently fantastic claims.

The great epidemic of 1837-1838 and 1839, which swept over most of Northern California, and which was estimated at the time to have taken between 60,000 and 100,000 lives, is described by Doctor Cook.

Correction.—In a footnote, appearing on page 76 of CALIFORNIA AND WESTERN MEDICINE for August, 1939, the Bureau of Public Administration of the University of California was erroneously referred to as the Bureau of Public Health Administration. The error consisted in the inclusion of the word "Health." The department is officially known as the Bureau of Public Administration.

Pituitary Growth Hormone Purified Further at the University of California.—Characterizing their accomplishment as "seeming of the greatest importance in establishing the individuality of this hormone," four University of California scientists have announced that they have succeeded in obtaining an almost pure extract of the growth hormone secreted in the human body by the anterior pituitary gland.

The announcement was made in *Science*, technical magazine, by Dr. Herbert M. Evans, Dr. Miriam E. Simpson, Dr. Heinz L. Fraenkel-Conrat, and Donald L. Meamber, of the University's Institute of Experimental Biology.

The growth hormone, first isolated at the University by Doctor Evans and a colleague, Dr. J. A. Long, controls the general development of the body. If the pituitary produces an excess of this hormone, abnormal development, even gigantism, may result. On the other hand, if there is a deficiency of this growth-stimulator, the body will not develop to normal size.

For several years University scientists have been attempting through chemical treatment to separate the growth hormone from other substances secreted by the pituitary. When final purification is obtained, Doctor Evans believes, the hormone may be used to produce spectacular improvement in children stunted by pituitary deficiency.

In the experiments reported, the growth hormone was freed of two and possibly more of the specific products of the gland.

Survey Gives Graphic Picture of Medical Lack.—Efforts of the State of California and the state organizations of medical men to extend adequate health service to all has occasioned a searching survey of health insurance projects, both state and national, by the Bureau of Public Administration of the University of California. The survey, which was requested by a number of the members of the State Legislature, shows that 41.68 per cent of the families in the United States are too poor to meet the full cost of adequate care. Forty-seven per cent of this number are unable to provide any sort of medical or dental care.

According to the survey a total of 40,000,000 persons in the United States were in families subsisting on an emergency standard of living in 1938. Twenty million persons represented families that were dependent upon the public, and 20,000,000 additional were in the marginal-income class which cannot meet the cost of sickness.

The conclusion reached in the survey is that "the average family requires protection from the uncertainties and costs of sickness."

Health insurance has been a matter of public interest in California since 1915, when a Social Insurance Commission of five persons was named by Governor Johnson. It rendered a report to the 1917 legislature, recommending the establishment of a voluntary social health insurance system under the supervision of the State Insurance Commission. Pursuant to the Social Insurance Commission's report, the Legislature, by a two-thirds vote of both houses, proposed a health insurance amendment to the Constitution. The amendment was beaten by the people by a vote of 358,324 to 133,858.

No further legislative action was taken until 1935, when the depression promoted a bill for the establishment of a system of compulsory health insurance for persons earning less than $300 a year. The bill died in committee.—*University of California Clip Sheet.*

Improvements in the British Medical Journal.—At the representative meeting, Dr. R. G. Gordon, Chairman of the Journal Committee, said that the new *Key to Medical Literature* had met with much appreciation. It contained more than twice the number of abstracts that its predecessor, the *Epitome,* did. An endeavor had been made to prepare for an emergency by interrupting the series of general practitioner articles by a special war series. With regard to the special journals published by the Association, for the first time one had shown a credit. The *Journal of Neurology and Psychiatry* in new form had increased its subscription list. The *British Heart Journal* already had a subscription list of nearly 400. Arrangements had been made for a *Journal of Thoracic Medicine and Surgery.* One member was perturbed at the increasing cost of the *British Medical Journal.* He thought it ought to pay for itself, and one of the reasons why it did not was that it was much too large; the only people who could read it all were retired and semi-retired practitioners! Doctor Gordon did not think it desirable to state how much of the members' subscriptions went to the *Journal.* No such periodical could meet all its expenditures from its own revenue, and the American Medical Association allotted more than half its revenue to its journal, while the proportion for the *British Medical Journal* was less than one-sixth.—From the American Medical Association Correspondent, in the Letters Department, *Journal of the American Medical Association,* August 19, 1939.

Federal Allocations for Venereal Disease Control.—"The sum of $4,379,250 will be allotted to the states for venereal disease control programs during the coming twelve months," Dr. Thomas Parran, Surgeon-General, United States Public Health Service, recently announced.

This expenditure is made possible by the LaFollette-Bulwinkle Act of 1938, which authorized an appropriation of $5,000,000 for the fiscal year 1940. Allotments to the states constitute 86.9 per cent of the total amount available for venereal disease control work. The remaining 13.1 per cent, amounting to $620,750, will be used for research, laboratory and field demonstrations, and administration.

The Federal allotment, which will be supplemented by state and local appropriations and by special grants from foundations and other private organizations, will represent a larger sum of money than has been available for venereal disease control programs in any previous year. Doctor Parran pointed out, however, that "funds now available do not yet approximate the estimates considered by medical and public health authorities to be necessary for the most effective public health campaign against syphilis and gonorrhea." It is expected that additional allotments from public and private sources will be sought for 1941.

The Federal Government's share for venereal disease control work in the states and localities during the next twelve months' period has been allotted on the basis of (1) population, (2) extent of the venereal disease problem, and (3) the financial needs of the various sections of the country.

In order to receive these grants, the Surgeon-General announced that the states must meet certain general minimum requirements in the prevention, treatment, and control of the venereal diseases. These requirements are based on recommendations adopted by the Conference of State and Territorial Health Officers on April 13, 1936. Federal funds for venereal disease control programs must be matched by state or local funds and must not replace funds from such sources already being used.

Radium Loaned to Hospitals by Federal Government. After consultation with state departments of health, the National Cancer Institute of the United States Public Health Service has recommended that about eight and one-half grams of Government-owned radium, valued at $180,000, be loaned to various hospitals in twenty different states and the Territory of Hawaii. . . .

Applications for the loan of radium for the treatment of cancer have been received from California, Colorado, Connecticut, Georgia, Kansas, Kentucky, Louisiana, Maryland, Michigan, Missouri, Nebraska, New Jersey, New York, North Carolina, Pennsylvania, Tennessee, Texas, Vermont, Virginia, Washington, and Hawaii.

Los Angeles County Hospital, Los Angeles, California, was the first hospital in its State to apply for a radium loan, and the application has been approved.

Because of its penetrating rays (next to cosmic rays, the most penetrating of all rays), radium is useful in treating cancerous growths in parts of the body which are otherwise inaccessible. Although costly at the outset, radium can be used over and over again through thousands of years. It is scientifically estimated that radium loses only half its strength every 1,700 years.

In approving the various applications, officials of the National Cancer Institute made their choices on the basis of need for radium and the competence of staff and adequacy of facilities for radium treatment. Needs are much greater in some areas of the country than in others although practically all states and sections could use more radium to advantage if they had it. Authorities state that there should be two grams of radium for every million persons, but it is reliably estimated that only about 133 grams are in use in the United States at the present time.

The National Cancer Institute still has about 1,300 milligrams of radium which have not been allotted on a loan basis, and applications for radium loans will continue to be considered. Institutions receiving the Government-owned radium have to agree to make no charges to the patients for its use and meet high standards regarding personal administration of the treatment.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Opponent of Chiropractors' Measure Says "Deck Stacked" *

Sacramento, August 22 (AP).—A Redwood City attorney charged today that the selection of persons to write pro and con arguments on the chiropractors' initiative on the November 7 ballot is a "clear case of stacking the deck" against opponents of the proposal.

The attorney, Frank V. Kingston, writing in behalf of the Chiropractic League of California, said Lieutenant-Governor Ellis E. Patterson "must have been misled and imposed upon" when he named five persons to prepare the arguments.

Meanwhile, Charles J. Hagerty, Deputy Secretary of State, said a comparison of copies of the two arguments showed they were written on the same typewriter and on paper with identical watermarks.

The initiative increases the powers of the Chiropractic Board; raises educational requirements of applicants for licenses and declares licensees shall report communicable diseases and sign birth and death certificates. State law provides that the Lieutenant-Governor must name persons to write arguments pro and con so that they may be studied by the voters.

It was the selection of the persons to write opposition arguments which brought the protest from Kingston.

The arguments received by Hagerty today showed Dr. W. Franklin Morris of Berkeley, member of the State Board of Chiropractic Examiners; Dr. Stanley M. Innes, San Jose, past president of the Affiliated Chiropractors of California, and Dr. George E. Swanson, Berkeley, President of the Affiliated Chiropractors of California, Alameda-Contra Costa Unit, wrote in favor of the initiative.

The opposing argument was signed by Mrs. Elsie James and Mrs. Mildred S. Potts of Berkeley.—Los Angeles *Times,* August 23.

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Chiropractors Win Initiative Row

Examiner Bureau, Sacramento, Aug. 23.—Lieutenant-Governor Ellis E. Patterson informed the Secretary of State's office today he will appoint new writers to prepare arguments against a chiropractic initiative measure to be submitted to the people at the November 7 special election.

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* For editorial comment, see page 147.

Patterson's announcement followed charges by the Chiropractic League of California, opposing the measure, that authors of the arguments for and against the measure were guilty of collusion. Under the constitution the Lieutenant-Governor appoints writers for arguments on all ballot propositions.

Dr. Stanley M. Innes, San Jose, Dr. George E. Swanson, Berkeley, and Dr. W. F. Morris, Oakland, wrote the favorable arguments. Innes, the league charged, assisted Mrs. Elsie James and Mrs. Mildred S. Potts of Berkeley to prepare the opposing argument.

An investigation by the Bureau of Criminal Identification indicated both pro and con arguments had been written on the same type of stationery and the same typewriter.—San Francisco *Examiner*, August 24.

* * *

Chiropractors Get Support in Fight

Convention Favors General Hospital Unit

Backing for the Los Angeles College of Chiropractic's fight to obtain General Hospital recognition in the form of a fifty-bed unit in which chiropractic treatments may be given was pledged yesterday by the American Progressive Chiropractic Association in convention here with more than fifteen hundred delegates.

The support took the form of a resolution offered by Dr. Charles W. von Walden, president of the Associate Alumni Association of the college.

The convention will end today with a "perfect man and perfect woman" contest.—Los Angeles *Times*, August 5.

* * *

Health Insurance *

State Employees to Sign

The California Physicians' Service, health insurance organization sponsored by the California Medical Association, got off to a flying start yesterday when the California State Employees Association, with its membership of nineteen thousand, agreed to accept the service.

The formal contract will be signed Monday, twenty-four hours before present policies of the association with a private insurance company expire.

Membership is voluntary, but those State employees earning $3,000 a year or less who do sign up will have available the services of 5,000 physicians and surgeons, as well as facilities in virtually all recognized hospitals in the State.

Under regulations announced recently, beneficiaries are offered complete medical and surgical care for one year for any illness or injury, hospitalization for twenty-one days, at a cost of $2.50 per month. An alternative "deductible" plan, at $2 monthly, gives them the same privileges provided they pay for the first two physician calls.

This prepaid service is for employed groups of five or more, and no physical examination is required. Exceptions noted yesterday were mental cases, drug addiction, chronic alcoholism, injuries sustained as a result of lawlessness or those self-inflicted, or those covered by workmen's compensation.

Medical and childbirth care will be provided only after the mother has been a member of the CPS for two years or more. Treatment will not be given for conditions existing at the time of issuance of policies.

The State has been divided into twenty-one districts, with a deputy medical director in each. Under these are additional assistant deputies, placed at points so as to make available the CPS to virtually every citizen.

Dr. Ray Lyman Wilbur, president of Stanford University and former president of the American Medical Association, is president of the service. Dr. Morton R. Gibbons, Sr., of San Francisco is medical director, and Dr. E. Vincent Askey of Los Angeles is assistant medical director. State headquarters are maintained in San Francisco.—San Francisco *Chronicle*, August 12.

* * *

Narcotic Bill's Signing Hailed as Major Step

Underworld Left Without Source, Says Official

Signing of Assemblyman Edward O'Day's bill to curb the narcotics evil by Governor Olson yesterday was hailed as a major advance in the battle against the dope habit by Paul Madden, chief of the State Narcotic Enforcement Bureau.

The bill, according to Madden, requires all prescriptions for narcotics to be made out in triplicate, and will aid in preventing medicinal narcotics from reaching the underworld.

Narcotic prescription records, according to the bill, henceforth will be kept on file by the enforcement bureau, by the pharmacists and by the physicians, thus reducing the chances for forged prescriptions being honored.

At least 1,100 forged prescriptions have been used by addicts to obtain supplies of narcotics in San Francisco and Los Angeles during the past two years, Madden estimated.

The enforcement chief was assisted in the drafting of the O'Day bill by the California Medical Association, the State Board of Pharmacy and pharmaceutical associations of both southern and northern California.—San Francisco *Examiner*, July 27.

* * *

U. S. Appeals Ruling on Medical Group

Washington, July 31 (AP).—The Justice Department asked the United States Court of Appeals today to overrule a lower court decision that the American Medical Association could not be prosecuted on charges of violating the Sherman Antitrust Act.

Justice Proctor of the United States District Court ruled last week that the practice of medicine was a "learned profession," not a "trade," and therefore did not come under the provisions of the antitrust law.—San Francisco *Chronicle*, August 1.

* * *

Senate Approves Health Program

Washington, Aug. 4 (AP).—The Senate Labor Committee gave its endorsement today to broad outlines of a proposed national health program, but withheld until next year its specific recommendations for legislation.

In a preliminary report to the Senate on a bill by Senator Wagner (D., N. Y.) to authorize annual Federal grants to states for various types of health service, the committee said it favored the objectives and intended to report the measure favorably at the next session of Congress with a number of amendments.—San Francisco *Chronicle*, August 5.

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Associated Women Hear Survey of Western Rural Health

The farmers of the eleven western states do not want compulsory health insurance, but they do want improved hospital and health service on a voluntary coöperative basis.

That was the result of a study made by the Associated Women of the Farm Bureau, as reported at the Santa Cruz conference by Mrs. Florence B. Bovett of Reno, regional director.

There are 937 hospitals in the eleven western states. In a total of 305 counties there are 105 county hospitals. The average distance from the ranch to medical service varies between ten and forty-five miles, and there are 4.76 hospital beds for each 1,000 persons.

The average cost of medical service is $3 for office calls, and $1 a mile for home calls—one way.

Mrs. Bovett was able to compile the average family cost of medical service for three states. The figures are $90 a year in Utah, $70 a year in Nevada and $79.25 a year in California.

These health costs are more than coöperative fees would be, and they do not represent complete health service since many persons neglect their health because of the cost or the uncertainty as to what the cost might be. In coöperative medicine, the doctors are busier and have greater income, while the members get more medical service for a lesser cost.

The eleven western states are all watching the coöperative plan which the California Medical Association is launching. This is the sort of service for which farmers have long asked.—El Centro *Imperial Enterprise*, July 6.

* * *

Medical Aid on a Repay Basis Here

Prepaid medical service is here for those who wish to take advantage of it, according to Dr. Henry S. Rogers, who was the speaker at the Wednesday luncheon of Petaluma Lions Club.

Doctor Rogers explained the plan of the newly formed California Physicians' Service, which was set up this spring for the benefit of those who wish medical service on a prepay basis.

The way was paved for the California Physicians' Service by two decisions of the California Supreme Court which decreed that such a plan was legal if the patient had free choice of physician.

The result of the decisions was to speed up the activity of the California Medical Association, which has been considering a plan of this type for many years and which had made extensive studies in an effort to develop the best protection for subscribers to the service.

The California Physicians' Service is a nonprofit corporation which has 5,000 professional members, about two-thirds of the physicians practicing in California, who will be available to persons who have policies. At the present time, groups are being affiliated with the service, but soon the benefits will be available to individuals.

* See also C.P.S. Bulletins, on pages 184-186.

The policies provide for complete medical and surgical treatment, with few exceptions, although some types of treatment are not covered until membership has been held for a stated period. Hospitalization and medicine are not covered. The monthly fee is about the average for one visit to a physician and the price was based on the average cost of caring for a patient in the United States, which figures were available from Government statistics.

A telegram was received from President George Dickerson, who is attending the International Lions convention at Pittsburgh, Pa., which conveyed greetings to the local club from International President Walter Dexter and himself.

Vice-President Robert Deitlein presided. Ellis H. Newsome was fellowship chairman and introduced Doctor Rogers, who is an officer of the California Medical Association.—Petaluma *Argus-Courier*, July 20.

* * *

Olson Accused of Favoring Own M.D.'s

In his eagerness to build up a political machine with the State relief administration, Governor Olson has even attempted to oust members of the medical staff and replace them by faithful Olson Democrats.

This amazing charge was made yesterday by Dr. H. Dewey Anderson in his letter of resignation as State relief administrator. Charging Governor Olson with introducing the spoils system on all fronts in the SRA, Anderson makes this specific allegation:

"The scrutiny of political affiliations of present (SRA) staff has gone to such an extent that a recent communication from the Governor's office indicated pointedly that in the medical staff employed as certifying physicians in Los Angeles County there were several physicians whose places might well be taken by deserving Democratic M.D's.

"This, my dear Governor, is a charge which has been vigorously advanced by leaders in the California Medical Association and the American Medical Association of what may well occur when any aspect of medicine is subjected to political control.

"It is a dangerous step to take, for there is no such thing as a partisan approach to the problems of medicine."—San Francisco *Examiner*, August 15.

* * *

New Laws Total 1,124 *

Governor Signs 1,077 Measures Out of 1,397 Passed by Legislature

California will have 1,124 new laws, records of the office of Secretary of State showed yesterday as Governor Olson and his staff relaxed from strenuous work in disposing of the last of the 1,397 bills handed him by the Legislature.

A survey of the records showed that Olson signed 1,077 bills. Bills that became law without the signature of the Governor, according to news dispatches from Sacramento, numbered 45. The Governor vetoed 142 bills. He killed 131 bills by "pocket veto," refusing to sign them before the expiration of the thirty days allotted him. The Legislature overrode the executive veto on only two measures.

The 1937 Legislature handed Governor Merriam 1,037 bills, of which he approved 933. . . .

Vetoed Measures

Bills which were vetoed included:

Assembly Bill 437, which would have prohibited advertising by drugless physicians on the ground that physiotherapists and naturopaths would be stopped from practicing without a physician's license, which they cannot obtain. . . .

Scientists Aided

A. B. 449, which would have required United States citizenship of anyone desiring a license to practice medicine. "This bill would eliminate practice by some of the world's greatest medical scientists," said the Governor. . . .—Los Angeles *Times*, July 27, 1939.

* * *

Need for Medical, Dental Care Is Shown by Survey

Effort of the State of California and the State organizations of medical men to extend adequate health service to all has occasioned a searching survey of health insurance projects, both state and national, by the Bureau of Public Administration of the University of California.

The survey, which was requested by a number of the members of the State Legislature, shows that 41.68 per cent of the families in the United States are too poor to meet the full cost of adequate care. Forty-seven per cent of this number are unable to provide any sort of medical or dental care.

According to the survey, a total of 40,000,000 persons in the United States were in families subsisting on an emergency standard of living in 1938. Twenty million persons represented families that were dependent upon the public and 20,000,000 additional were in the marginal-income class which cannot meet the cost of sickness.

The conclusion reached in the survey is that "the average family requires protection from the uncertainties and costs of sickness."

Health insurance has been a matter of public interest in California since 1915, when a Social Insurance Commission of five persons was named by Governor Johnson.

It rendered a report to the 1917 legislature recommending the establishment of a voluntary social health insurance system under the State Insurance Commission.

Pursuant to the Social Insurance Commission's report, the legislature, by a two-thirds vote of both houses, proposed a health insurance amendment to the Constitution.

The amendment was beaten by the people by a vote of 358,324 to 133,858.

No further legislative action was taken until 1935, when the depression prompted a bill for the establishment of a system of compulsory health insurance for persons earning less than $300 a year. The bill died in committee.—Turlock *Journal*, July 28.

* * *

Federal Grand Jury Manners

Anything like conclusions on the question whether the American Medical Association has been guilty of restraint of trade in its efforts to resist the advance of certain types of group medical service must, of course, be deferred until the suit of the Department of Justice has been finally decided on appeal. But certain comments of Justice Proctor of the District of Columbia court on the terms of the indictment brought in this case need not escape the layman's attention.

The decision against the Government on the main issue rests upon what to most of us will appear to be a fine-drawn distinction between a "trade" and a "profession." Justice Proctor holds the distinction to be sufficiently real, under ruling decisions of the Supreme Court, to exempt doctors from the application of the Sherman antitrust law. He expressly excludes the question whether the association may have wrongfully injured the group doctors in their means of livelihood. As to that, he says:

"So here, if the livelihood of group practitioners has been injured by the wrongful acts of the defendants, they, too, have redress in a civil court. But the charge in the present case is criminal, and to stand must find its sanction solely in the statute."

Whether the Supreme Court will agree with Justice Proctor that the Government's contentions in this case represent "an extreme position which does violence to the common understanding of 'trade,' rejects authoritative decisions of our courts and ignores cardinal rules of statutory construction" and that "it is not for the courts to stretch an old statute to fit new uses for which it never was intended," remains to be seen. But, in view of the current predilection of the Department of Justice for the consent decree method of getting results, there is an immediate interest in what this decision has to say about the contents of the indictment. Justice Proctor says of that instrument:

"It is questionable whether some of it would be deemed relevant or competent in proof of the offense. Every indictment should be confined to a clear and dispassionate statement of essential facts. . . . Ordinarily, improper matter in the indictment, unnecessary to support the charge, will not vitiate an indictment. It will be treated as surplusage and disregarded. But I doubt if such treatment would suffice to relieve these defendants of the prejudice likely to arise by an indictment which smacks so much of a highly colored argumentative discourse against them. It must be remembered that when a case is finally submitted to a jury for their secret deliberations the indictment goes with them."

From which it is perhaps a reasonable inference that Assistant Attorney-General Arnold will caution Federal grand juries—or whoever writes their indictments—to mend their manners toward persons they hale before them. —Pacific Coast *Wall Street Journal*, August 1.

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Hospital Aid Fears Cited

Catholic Objection to Federal Assistance Explained in Debate

Denver, Aug. 7 (AP).—The nation's health chief and a Catholic hospital leader debated tonight the issue of increased Federal aid for private hospitals before the National Conference of Catholic Charities.

"I can see no fundamental objection to providing Federal assistance for the building and modernizing of nonprofit hospitals and feel that public funds should be available to care for needy patients in voluntary as well as

* See also, on page 186.

public hospitals," declared Surgeon-General Thomas Parran of the United States Public Health Service.

Church Fears to Yield

"The Catholic Church fears to yield an iota in the approach to the problem of the responsibility for the indigent," countered Rev. Alphonse M. Schwitalla, S. J., of St. Louis, president of the Catholic Hospital Association.

Doctor Parran said the proposed national health program of expanded Federal aid intends that "the widest latitude should be left to the states."

Opposition Explained

Explaining the Catholic hospital's "crisis reaction" of opposition to the proposed Federal program, Father Schwitalla said:

"The Catholic hospital fears the necessary impersonalities of sickness and health care under Government contact.

"It is concerned with the maintenance of the spirit of our religious orders, their traditions and the inspiration of the lives of their founders and their hero members.

Seen as Menace

"It views with a measure of apprehension the mounting subsidies that might be voted by Congress for official programs of medical care because the partnership between the public and private agency might be weighted by goods of this earth."

Father Schwitalla declared the program "constituted a threat to the individuality of the Catholic hospital, and hence to its continual service, and hence to its continued existence."

Aid Proposed

Doctor Parran said the national health program proposed aid to hospitals because "the modern physician makes increasing use of facilities for the diagnosis and treatment of disease which are most effectively supplied by hospitals."

"The national health program, therefore, provides aid for the construction and maintenance of hospitals—though only where needed—and for the support of existing hospitals—public, church and voluntary alike—especially in distressed and rural areas."

Fear Dictatorship

The Catholic Hospital Association had contended that a veritable dictatorship by the Federal Government of the nation's medical facilities would result from the program.

"It is not proposed," Doctor Parran continued, "that the health and medical services of the country be federalized.

"The widest latitude should be left to the states in developing procedures and policies best adapted to their own needs."—Los Angeles *Times*, August 8.

* * *

Convention

Nurses' Four-Day Session Ends

The California nursing organizations closed their four-day convention here last night, August 17, with a banquet at Hotel St. Francis, attended by more than five hundred delegates.

Organizations represented were the California State Nurses' Association, the California League of Nursing Education, and the California State Organization for Public Health Nursing.

Pauline Gage of Pomona was chosen president of the California State Nurses' Association; Margaret Tracy of University of California Hospital, first vice-president; Edith H. Smith of Stanford Hospital, second vice-president; and director: Gertrude Folendorf of San Francisco, Edna L. Hedenberg of Los Angeles, and Jennie W. Gardner of Davis.—San Francisco *Chronicle*, August 18.

* * *

State Needy Aid Costs Triple

Records Disclose Great Increase in Number of Cases in Three Years

Sacramento, Aug. 21 (Exclusive).—The cost to California of granting aid to the elderly, the needy blind and dependent children has approximately tripled in the last three years, records of the State Department of Social Welfare disclosed today.

In June of this year, the cost of the three aids amounted to $5,256,653, being divided as follows: Elderly aid, $4,282,347; blind aid, $311,035; dependent children aid, $663,271.

In July of 1936, the State paid out only $1,823,792, as follows: Elderly aid, $1,405,267; blind aid, $145,241; dependent children aid, $273,104..

The records show that the major part of the increase is due to the jump in the number of cases. During the time the number of pension cases has jumped from 44,905 to 131,879, blind from 4,271 to 6,476 and children from 20,744 to 38,679.—Los Angeles *Times*, August 22.

LETTERS

Subject: Prenatal and Premarital Laws.*

(COPY)

San Francisco, August 23, 1939.

Roy E. Thomas, M. D., Chairman
California Medical Association Committee on
Health and Public Education
San Francisco, California

Dear Doctor Thomas:

Re: Premarital Examinations

Replying to your letter of July 26, 1939, in which you requested a brief opinion as to the duties and obligations of physicians and laboratories in the State of California under Chapters 127 and 382 of the California Statutes of 1939, which become effective September 19, 1939, our opinion is as follows:

Chapter 382. Premarital Examination.—The contents of this statute are as follows: Before any applicant for a marriage license can receive the same, he must present a certificate from a duly licensed physician, which certificate shall state that the applicant has been given such examination, including a standard serological test, as may be necessary for the discovery of syphilis, made not more than thirty days prior to the date of issuance of such license, and that in the opinion of such physician, the person either is not infected with syphilis. or if so infected, is not in a stage of that disease which is or may become communicable to the marital partner. Any person who is by law able to obtain a marriage license is able to give consent to any examination and test required by the statute. The certificate is made on a form provided and distributed by the State Department of Public Health.

The type of test which can be used to comply with the statute shall be a test for syphilis approved by the California State Department of Public Health and the laboratory which can make such test may be any laboratory approved by the California State Department of Public Health, or any other laboratory, the director of which is licensed by said State Department of Public Health according to law. When a laboratory makes a test, it submits the original of a laboratory report to the physician, together with the certificate form which the physician will make out for the patient. A copy of the laboratory report is kept by the laboratory and a second copy sent to the State Department of Public Health.

The certificate, laboratory statement or report and all other papers connected with these examinations are declared to be confidential, and neither the physician nor any other party is allowed to divulge the contents of such report to any person other than the state or local health officers or their duly authorized representatives.

Other sections of the statute deal with instances in which parties may obtain a marriage license without examination by application to the Superior Court, penalty for misrepresentation by applicant and expenses of administration of the statute. One other important provision is to the effect that whenever any question arises as to the accuracy of tests, it is mandatory upon the State Department of Public Health to accept specimens for checking purposes from any district in the state.

COMMENT

(a) *Effect Upon Physicians.*—Most of the duties and liabilities of physicians under this statute can be clearly ascertained from the above. However, there are one or two points which should be kept in mind. The information *must be kept confidential.* In addition to the principles of medical ethics which do not permit one to divulge confidential communication, the statute provides that anyone

* See also, on pages 145-146, 200-202, and 208-211.

who gives out information concerning a premarital test is guilty of a misdemeanor.

Possibility of Liability of Physicians.—There are two possible sources of liability, as follows: (1) A physician who refuses to grant a certificate may be sued by the applicant if it later develops that the certificate should have been granted; and (2) A physician may grant a certificate though syphilis in a communicable stage is present and may be subsequently sued by the other spouse for damages sustained as a result of contracting the disease from the applicant.

The only suggestion that can be made with reference to avoiding all possible liability is to warn physicians *to use the utmost care* in selection of laboratories, in analyzing the laboratory report and in stating their conclusion. It is a well-established principle of law that a plaintiff cannot succeed in an action against a physician merely by establishing that the physician was guilty of an error of judgment; provided, however, that the physician is qualified and has done what he thinks best after a careful examination. This rule does not relieve a physician from his duty to use his best judgment. It should also be suggested that a physician should constantly keep himself abreast of the times and acquaint himself with any new developments in the field of premarital examination. *Most important is to bear in mind constantly that the actual test used must be of a type approved by the State Department of Public Health.*

(b) *Laboratories.*—In addition to the brief statement, set forth above, of the duties and obligations imposed by the statute, it should be stated that the certificate furnished to the applicant is accompanied by a statement from the person in charge of the laboratory making the test, or from some other person authorized to make such reports, setting forth the name of the test, the date it was made, the name and address of the physician to whom the test was sent, and the name and address of the person whose blood was tested. Both the forms for laboratory reports and certificate are furnished to the laboratory by the State Department of Public Health.

Standard Serological Test.—Although the statute refers to the test which should be given as a single test, the State Director of Health, Dr. Walter M. Dickie, has ordered that all blood samples taken must be submitted to two types of test for disease detection. Each applicant must pass a Wassermann type test and a precipitation test. Of the Wassermann type he has approved the Kolmer, Eagle and Craig tests, and of the precipitation group, he has approved the Kahn, Kline, Eagle and Hinton tests.

Possibility of Liability of Laboratory.—Although the statute provides that whenever there is a question as to the accuracy of these tests, specimens can be submitted to the State Department of Public Health for final determination, the need for great care by the laboratory cannot be overemphasized. A mistake caused by the negligence of the laboratory may result in liability to both the applicant and the referring physician and, in addition, to the other spouse.

* * *

Chapter 127. Prenatal Examination.—Section 1 of this statute reads as follows:

"Every licensed physician and surgeon or other person engaged in prenatal care of a pregnant woman or attending such woman at the time of delivery shall obtain or cause to be obtained a blood specimen of the pregnant or recently delivered woman, at the time of the first professional visit or within ten days thereafter. The blood specimen thus obtained shall be submitted to an approved laboratory for a standard laboratory test for syphilis. For the purposes of this act, an approved laboratory shall be a laboratory approved by the California State Department of Public Health, or any other laboratory the director of which is licensed by said State Department of Public Health according to law. In submitting such specimen to the laboratory the physician shall designate that this is a prenatal test or a test following recent delivery."

Other sections of the Act state that a standard laboratory test shall be a test for syphilis approved by the California State Department of Public Health, that in case of question of accuracy of tests prescribed in the Act, the State Department of Public Health must accept specimens for checking; that the Department of Public Health shall furnish the laboratory report form which must be distributed to the laboratories upon request; that the laboratory must submit the original report to the physician, keep a copy for itself, and send copies to the State Department of Public Health; that the reports must be kept confidential and can only be inspected by an authorized representative of the California State Department of Public Health; and, finally, Section 5 provides as follows:

"Sec. 5. Any licensed physician and surgeon, or other person engaged in attendance upon a pregnant woman or a recently delivered woman, or any representative of a laboratory who violates the provisions of this Act shall be guilty of a misdemeanor; provided, however, every licensed physician and surgeon or other person engaged in attendance upon a pregnant or recently delivered woman, who requests such specimen in accordance with the provisions of Section 1, and whose request is refused, shall not be guilty of a misdemeanor."

COMMENT

(a) *Duties and Obligations of Physicians.*—It should be noted that there are two situations in which the physician *must* act under the statute. The situations and acts required are as follows:

1. Every physician who is engaged in prenatal care of a pregnant woman must obtain a specimen at the time of the first professional visit or within ten days thereafter.

2. Any physician who is attending a woman at the time of delivery must obtain a specimen.

The statute is not clear as to the period of time after delivery in which the specimen can be obtained. A reasonable construction of the statute would seem to be that the specimen should be obtained within ten days after delivery of the child.

(b) *Liability and Procedure in Event of Patient's Refusal to Permit a Test.*—Section 5 of the statute is somewhat ambiguous in that it provides that a physician need only make a request for the specimen in accordance with the provisions of Section 1. However, since Section 1 imposes an absolute duty to obtain the specimen, the particular type of request which should be made is indefinite.

All physicians must take precautions to have definite proof that such a request was made. Thus, the attending physician, if possible, should secure a signed statement from the patient. If that is impossible, then, at least one disinterested witness should be present when the request is made and refused. In addition, after an oral refusal a written request should then promptly be made.

Since the physician is not, as in the premarital examination law, required to render an opinion as to the existence or nonexistence of syphilis, liability for mistake on that score is not present.

(c) *Duties and Responsibilities of Laboratory.*—The same comment made in the discussion of negligence by laboratories in making premarital tests applies to the tests required under this law.

As the duties and obligations of doctors of medicine under these statutes are far-reaching and of great public importance, it is suggested that all members of the California Medical Association be acquainted with the exact provisions thereof and their duties and possible liabilities thereunder.

111 Sutter Street.

Very truly yours,

(Signed): HARTLEY F. PEART.

Subject: Premarital examinations under the New York law.*

In connection with the California laws on premarital examinations, recently enacted, the following communication from the New York Department of Health may be of interest:

(COPY)

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Albany, New York, August 4, 1939.

To the Editor:—The New York State Legislature in 1938 passed a law requiring a physical examination, including a standard serological test for syphilis, on all applicants for marriage licenses within the state.

Several instances have been called to my attention in which residents of other states have had difficulties in securing marriage licenses in New York State because of misinterpretations of the law by themselves or their examining physicians. In order that such inconveniences may be avoided, I should greatly appreciate it if you would, through your Journal, inform the medical profession of your state of the provisions of the New York law.

That part of the Act as amended and effective July 1, 1939, referable to those examinations, reads as follows:

"Physician's examination and serological test of applicant for marriage license. (1) Except as herein otherwise provided, no application for a marriage license shall be accepted by the town or city clerk unless accompanied by or unless there shall have been filed with him a statement or statements signed by a duly licensed physician or by a commissioned medical officer of the United States Army, Navy, or public health service that each applicant has been given such examination, including a standard serological test, as may be necessary for the discovery of syphilis, made on a day specified in the statement, which shall not be more than the thirtieth day prior to that on which the license is applied for, and that, in the opinion of the physician, the person therein named is not infected with syphilis, or if so infected is not in a stage of that disease whereby it may become communicable."

The law further states that "a standard serological test shall be a laboratory test for syphilis, approved by the State Commissioner of Health, and shall be performed by the state department of health, or in the city of New York by the department of health of such city, or at a laboratory approved for this purpose by the state department of health, or in the city of New York by the department of health of such city."

I offer the following comments relative to its interpretation:

1. A duly licensed physician means any physician duly licensed to practice medicine in the state in which he resides or in which he maintains his office.

2. The date of examination is interpreted to mean the date on which the specimen of blood is taken.

3. The state commissioner of health and the state department of health referred to mean Commissioner of Health of the State of New York and the New York State Department of Health.

4. Laboratory tests made as a part of premarital examinations for persons applying for marriage licenses in New York State, outside of New York City, as well as the laboratories in which these tests are performed, must be approved by the New York State Commissioner of Health. For administrative reasons laboratories within New York State only have been approved for tests on applicants for licenses in the state, exclusive of New York City.

5. The Commissioner of Health of the city of New York has approved certain out-of-state laboratories for the performance of serological tests on persons applying for marriage licenses in New York City. Requests for information concerning laboratories approved by the New York City Department of Health should be addressed to that department at Worth and Centre Streets, New York City.

Outline of procedures for examination of out-of-state applicants for marriage licenses in New York State, exclusive of New York City:

1. Any physician duly licensed to practice medicine in the state in which he resides or in which he maintains his office may perform the necessary physical examination.

2. The specimen of blood must be sent to an approved laboratory in New York State. It is suggested that specimens be sent to the Division of Laboratories and Research, New York State Department of Health, New Scotland Avenue, Albany, New York, where examinations will be made free of charge.

3. The specimen should be labeled "for premarital examination."

4. The use of air mail is recommended when the specimen must be sent a great distance.

5. Upon completion of the test the laboratory will send the physician, in addition to the usual laboratory report, a certificate to the effect that the serological test was performed as a part of a premarital examination.

6. If, in the opinion of the examining physician the applicant is free from syphilis or does not have the disease in a stage which may become communicable, he should complete the certificate as indicated thereon.

7. The certificate is given to the applicant who will submit it to the clerk when the marriage license is applied for.

If these procedures are followed, there should be no difficulty in obtaining the license.

For further information relative to the marriage of persons in New York State, exclusive of New York City, communications should be addressed to the Division of Syphilis Control, New York State Department of Health, Albany, New York.

Very truly yours,

(Signed): EDWARD S. GODFREY, JR.,
Commissioner of Health.

Subject: Fight against nostrums and quackery. Request for coöperation.

(COPY)

FEDERAL TRADE COMMISSION
WASHINGTON

July 14, 1939.

To the Editor:—In a recent conference with Dr. Olin West, a problem of mutual interest to the medical profession and the Federal Government was discussed. It is at the suggestion of Doctor West that I am writing you this letter.

At great hazard, not infrequently involving costly and harassing suits for libel, the American Medical Association has for many years been conducting a valiant fight against nostrums and quackery. Through these means an invaluable service has been rendered to the profession as a whole, and to every individual member. Various aspects of this service should be obvious to any physician. The Association, however, is without regulatory powers. Through the pages of the *Journal* and otherwise it can expose falsehood and advise against it, but it lacks the authority to specify and enforce the limits beyond which the advertiser of a product may not go in representing to the public the merits of a proprietary preparation.

Fortunately, however, there is an agency clothed with this authority and charged with this responsibility. This is the Federal Trade Commission which has jurisdiction over false and misleading advertising. In this capacity the Federal Trade Commission is the medium through which the ambitions of the medical profession with respect to false advertising can be realized. It is believed, therefore, that the successful accomplishment of this objective should

* For information concerning the California premarital law, refer to CALIFORNIA AND WESTERN MEDICINE, issue of August, 1939, on page 139.

be of vital interest to every member of organized medicine. It is, however, a problem which will require the unreserved support of medical organizations and their constituent membership. Whenever a case is contested it is necessary to introduce competent medical testimony in support of the Government's charges. You, as the secretary of the State Medical Society, know the proper men to whom to appeal within your state for such assistance. Moreover, an appeal from you is much more direct and personal than such an appeal coming from me or from even the office of the American Medical Association in Chicago.

When hearings are necessary it is the policy of the Federal Trade Commission to schedule the hearing at or near the place where the headquarters of the respondent are located, so that little or no travel will be involved. I am in a position also to assure you that medical witnesses will be treated courteously and that every possible consideration will be given to the conservation of their valuable time, and to other items to suit their convenience. Though it is regretted that the Federal Trade Commission has not been provided with funds with which to pay expert witness fees, it is believed that this problem is of as much concern to the medical profession as it is to the Federal Government, and that physicians in performing this service as acting in the interest of themselves and the profession as a whole.

I will very much appreciate an expression from you as to whether or not you wish to coöperate with me in the manner indicated, if and when the demand for such assistance arises.*

The recognition of the medical and public health significance of this problem is well illustrated by the fact that there has been recently created in the Federal Trade Commission a Medical Advisory Service to which I, as an officer of the Public Health Service, have been assigned as director.

Thanking you for an early reply, I am

Very truly yours,

(Signed): K. E. MILLER,
Senior Surgeon, United States Public Health Service.

* * *

(COPY)

FEDERAL TRADE COMMISSION
WASHINGTON

August 15, 1939.

To the Editor:—I am pleased to acknowledge your letter of July 25, in which you state that the facilities of the California Medical Association will be available in connection with the promotional work of the Federal Trade Commission in its campaign against nostrums and quackery.

It may be of interest to you to know that during the past two or three months the Federal Trade Commission has been conducting a series of hearings on a number of cases of this nature in California. The members of your Association have already given invaluable assistance in this connection. I want to assure you that the Federal Trade Commission is very grateful for this coöperation and especially gratified to know that when this service will be needed in the future it will be readily available.

In reply to your inquiry as to whether there would be any objection to the printing of my letter of July 14 in the official journal of the California Medical Association, you are informed that I would be very glad indeed to have you use my letter in this way.

Very truly yours,

(Signed): K. E. MILLER,
Senior Surgeon, United States Public Health Service.

* Reply was made that the officers and members of the California Medical Association would be happy to give cordial coöperation.

Subject: Letter of commendation to the secretary of the Board of Medical Examiners of the State of California.

BOARD OF MEDICAL EXAMINERS
STATE OF CALIFORNIA

August 14, 1939.

To the Editor:—At a recent meeting of the California State Board of Medical Examiners it was voted that I send to you the enclosed certified copy of a letter from the executive officer of the State Personnel Board, Louis J. Kroeger, sent by him to Dr. C. B. Pinkham of the Board of State Medical Examiners. It was believed that the statement herein contained not only concerns Doctor Pinkham as Secretary of the Medical Board, but more in particularly concerns all licensed regular men as to the manner of the transaction and records of the Board since 1913.

If you deem it to be in order, and proper, I believe that it would be of interest for this enclosed copy to be published in CALIFORNIA AND WESTERN MEDICINE. We would be pleased.

The Board would wish that their suggestion in this matter be entirely subject to your approval and judgment.

Thanking you for its consideration,

Sincerely and cordially,

(Signed): C. L. ABBOTT, M. D.,
Vice-President.

* * *

(COPY)

STATE PERSONNEL BOARD

Sacramento, March 14, 1939.

Dr. C. B. Pinkham
Board of State Medical Examiners
State Office Building
Sacramento, California.

Your record of state employment has come to my attention, from which I learn that you have recently completed twenty-six consecutive years of state service. I congratulate you on this record.

In the period of time during which you have served the public many changes in the organization and methods of state government have taken place, including the strengthening and extension of our merit system.

Even though we have had a civil service system in one form or another since 1913, records of such length of service as you have enjoyed are still the exception rather than the rule, and we pause to pay tribute to it.

We hope you may continue as long as you wish, to experience the satisfaction that a long and useful service must bring to you.

1025 P Street.

Very truly yours,

(Signed): LOUIS J. KROEGER,
Executive Officer.

Subject: Typhoid carriers and tuberculosis contacts in domestic help.

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

August 15, 1939.

To the Editor:—The enclosed letter has been sent to the state health officers throughout the United States and its territories as well as to full-time county health officers and city health officers in our larger communities.

The problem discussed in this letter is one of definite importance. Undoubtedly, appropriate action will be initiated in many sections, and it is hoped proper regulations set up in order to control this definite hazard to the children of this country.

Sincerely,

J. C. GEIGER, M. D., *Director.*

(COPY)

The Typhoid Fever Carrier and the Active Tuberculosis Case in Private Family Employment

Recently this department has been investigating two cases of typhoid fever in children of different families and a case of tuberculous meningitis in a child fifteen months of age.

In the first family suspicion centered on a domestic, E. A., female, age 46 years, who came to San Francisco from Norway in February, 1939. During her employment with family No. 1, a boy, age 13 years, came down with typhoid fever. Investigation of her stool specimens on four different occasions yielded one positive, indicating that she was a carrier of B. typhosus. It is also interesting to note that this domestic had a Food Handler's Certificate from a well-known health department.

Typhoid fever carrier No. 2, M. S., female, age 35 years, native of New Orleans, came to San Francisco in January, 1938. After she was in service ten months one of the children of the family came down with typhoid fever. Routine epidemiologic investigation of this second case of typhoid fever disclosed that the domestic, M. S., was a carrier of B. typhosus. It is significant that neither of these carriers ever gave a history of typhoid fever.

Epidemiologic investigation of a recently reported case of tuberculous meningitis occurring in a fifteen months old child revealed as the original contact focus a domestic, L. B., female, age 55 years, native of San Francisco. During the last few years she had a productive cough, but appeared to be healthy up to two months ago.

The two domestics revealed to be typhoid fever carriers and the domestic who finally collapsed with active pulmonary tuberculosis bring to the forefront the vital importance of physical and laboratory examinations of domestics who handle children, examination particularly for syphilis, tuberculosis, and for carrier conditions such as typhoid fever and diphtheria. Unfortunately, the laboratory findings in the latter two diseases may be negative at the time of examination and subsequently become positive. Again, it is the usual procedure that only one examinaton is made, and therefore certification is of doubtful value.

It is recommended, however, for earnest consideration that families employing domestics, and employment agencies specializing in this type of employment, offer further safeguards for the health of children in regulating and demanding physical and laboratory examinations that may be pertinent to the occasion and type of service. Your consideration of this problem will be appreciated.

MEDICAL JURISPRUDENCE†

IMPORTANCE OF KEEPING COMPLETE NOTES

By HARTLEY F. PEART, ESQ.
San Francisco

A physician can never determine what particular circumstances may subsequently develop into litigation or other controversy. Thus, in order to render the greatest possible aid to his patient and to himself, a physician should make very complete reports or notes concerning everything he does. This applies to records of operations and hospital after-care as well as to records of office calls.

Typical of the conflicts into which the physician may be drawn are disputes in criminal proceedings as to the nature of wounds and as to the manner in which they were received. Physicians have been subpoenaed to describe wounds long after the examination was made and, if experienced in such matter, to give opinions as to the manner in which the wounds were inflicted. Notes taken at the time of the examination are very helpful in recalling such facts.

Similarly testimony of receiving physicians as to the extent of lacerations, bruises and other injuries received in accidents is called for in determining the extent of damages suffered. Often this is not easy; for instance, when the witness may be asked whether or not the injuries were sufficiently extensive to have caused a subsequently appearing tubercular condition. Not only the visible condition of the patient, but, under some circumstances, even statements made by the patient at the time of treatment become highly important. Thus, when a patient in giving a history of his case states how he feels and acts, such statements may later be used against him as admissions, and under some circumstances used for his benefit.

In a local suit in which the writer took part, a number of physicians were sued for a million dollars as damages for an alleged false imprisonment. The plaintiff, in the middle of the night, had been found in bed singing, laughing, and apparently entirely out of her mind. After being held at a receiving hospital, she was committed to an asylum for a number of months. Suit was brought upon the theory that she had never been insane, but had undergone an intense nightmare, and while still under its influence had been so doped up by the physicians at the receiving hospital that she was unable to speak coherently to the committing judge. The case was dismissed, but had it ever come to trial, testimony of the physicians at the receiving hospital as to the exact nature of her mumblings and reactions would have been highly important to the success or failure of the litigation, and notes recalling such facts to mind, highly important to the witnesses.

Attending physicians are often the only persons to hear dying declarations, which may identify a wrongdoer. They may also hear statements made during a deceased's last illness, which statements become material in many proceedings, especially probate proceedings.

Although a difficult thing to do in many instances, it is wise to secure from the patient a written consent to certain procedures. Thus, before operation the patient's consent in writing should be obtained. This writing should contain a brief statement showing that the patient understands the nature of the operation. Again, when a patient insists on leaving a hospital against his physician's advice, a written statement should be obtained acknowledging the fact that he has been advised against the departure. Again, when a physician voluntarily or involuntarily relinquishes a patient to another physician, the patient's written consent to the same should be procured. Finally, a constant source of irritation is the plaintiff who refuses to have x-rays made although his physician recommends that he do so. When the treatment turns out unsatisfactorily, the patient often denies that any such recommendation was made. In such cases it is advisable for the physician before continuing the treatment to secure from the patient a signed statement that he refused to have an x-ray taken.

The importance of keeping complete notes can perhaps be stressed by stating that, in the opinion of many eminent jurists, the facts are more troublesome than the law in any legal problem. Judge Benjamin Cardozo once said:

> More and more we lawyers are awakening to a perception of the truth that what divides and distracts us in the solution of a legal problem is not so much uncertainty about the law as uncertainty about the facts—the facts which generate the law. Let the facts be known as they are, and the law will sprout from the seed and turn its branches toward the light.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

SPECIAL ARTICLES

INDEX

ESSENTIALS OF A REGISTERED HOSPITAL*

Prepared by the Council on Medical Education and Hospitals of the American Medical Association

General Statement.—Hospitals should be organized and conducted primarily for the purpose of providing facilities where the sick and the injured of the community may be given scientific and ethical medical care.

Registration is a basic distinction between all recognized hospitals and those that are refused recognition. It is a prerequisite to the consideration of a hospital for approval for interns or for residencies in specialties.

The registration of hospitals, the approval of hospitals for interns, approval for residencies in specialties, and all other service of the Association regarding hospitals is carried on by the Council on Medical Education and Hospitals. Separate essentials have been adopted for each of these types of approval.

It is the desire of the Council to coöperate in every way for the improvement of hospital service, whereby the sick and injured may be provided with scientific and ethical medical care.

The Council does not have nor does it assume legal authority over any hospital. It recognizes clearly that the officers in charge of such institutions have the unquestioned right to conduct the hospitals in any way they may deem wise. If a hospital desires to have its name appear on the American Medical Association Hospital Register and thus have the endorsement of that Association, it should be willing to comply with the principles which the Council on Medical Education and Hospitals considers necessary.

I. *Organization.*—1. The organization should consist of a supreme governing body qualified to administer a hospital. This may be a board of trustees or directors, a partnership, or an individual. Such a board, partnership, or individual must assume final authority and responsibility for the administration.

2. There must be a well-qualified executive officer who may be designated as administrator, superintendent or director, or by some other title. This person should be responsible to the governing body for carrying out its policies. The executive officer should be assisted by competent personnel adequate to the needs of the institution.

II. *Physical Plant.*—1. The hospital plant should consist of modern, safe buildings maintained in a sanitary condition, provided with fire protection and adequately equipped and furnished for the comfort of patients. Equipment for diagnosis and treatment should be reasonably complete for all types of work the staff purports to carry on in the hospital.

2. Institutions accepting surgical and obstetric patients should provide a modernly equipped operating room, a delivery room, and a nursery. Hospitals that are strictly limited in the service they offer are not expected to have the complete organization and equipment of a general hospital.

III. *Medical Staff.*—1. Since the medical staff is the most important factor in the delivery of medical service to patients, too great care cannot be exercised in the selection of staff members. The staff should be limited to physicians holding the degree of doctor of medicine from medical colleges acceptable to the Council on Medical Education and Hospitals, having satisfactory qualifications as to training, licensure and ethical standing, and to dentists who are graduates of recognized dental colleges and whose professional ability and standing are known to the medical staff.

2. Osteopaths, chiropractors, and other cult practitioners outside the scope of regular medicine, or unethical physicians, may not be permitted to use the hospital's facilities. They may not enter data on the records, carry out diagnostic procedures or treatments, or in any way assist in doing this work.

3. The form of organization of the staff is determined by the size and the activity of the hospital in accordance with its needs.

4. In very small hospitals where there are few physicians and where an elaborate organization is not practicable, there should still be some authority competent to pass upon the qualifications of those who seek to use the hospital's facilities. Particular care should be exercised in the assignment of surgical privileges since it is essential for the safety of patients that both the surgeon and his assistants be properly qualified.

5. Where further organization is needed, it should consist of such officers as president, secretary, and others; and committees, such as executive, medical records and credentials, elected or appointed according to the constitution and by-laws.

6. Staff departments, such as medicine, obstetrics, and surgery, should be organized as may seem wise.

7. Staff meetings should be held for the review of the work of the hospital, the discussion of results, the reports of autopsy and pathologic studies, the presentation of papers and such other matters as concern the professional work of the hospital.

8. Minutes of all staff meetings and attendance records shall be kept by the secretary.

IV. *Pathology and Laboratory Diagnosis.*—1. The laboratory facilities should provide as complete a service as is practicable.

2. The pathologist should preferably be a physician who holds the certificate of the American Board of Pathology. Where it is not possible to employ the services of a pathologist directly, arrangements should be made for a consulting service for tissues, postmortem examinations, and the interpretation of the more difficult tests and examinations in clinical pathology. All surgical tissues should be examined, described and diagnosed by a pathologist.

3. The department should be equipped for all routine procedures and for whatever additional tests and examinations are frequently called for by the staff.

4. At least one well-trained clinical laboratory technician should be employed.

5. Reports of all work done in the department should be kept on file.

6. Autopsies. Every effort should be made to secure consent for the performance of autopsies. They should be conducted by a qualified pathologist or under his supervision, and protocols, including clinical summaries, should always be filed.

V. *Radiology.*—1. The responsibility for all radiologic examinations must rest on the physician-roentgenologist who is head of the department. His findings and con-

* "Essentials of a Registered Hospital," as here given, bring the same up to the present. A former and less complete outline appeared in CALIFORNIA AND WESTERN MEDICINE, July, 1939, on page 69.

Reprinted from *The Journal of the American Medical Association*, May 27, 1939, Vol. 112, pp. 2166-2168.

clusions for all examinations should be placed in the patient's chart. Nothing in this provision should preclude additional study and interpretations by qualified attending physicians on the staff.

2. The physician-roentgenologist should be preferably one who is a diplomate of the American Board of Radiology or a physician whose qualification are acceptable to the Council on Medical Education and Hospitals of the American Medical Association.

3. It shall not be the policy of the hospital to make a profit from the department of radiology.

VI. *Anesthesia.*—The anesthesia service should be under the direction of competent medical personnel whenever possible. If a qualified specialist in anesthesiology is not available, supervision may be assigned to some member of the staff who has had special training in this field or to a nurse anesthetist whose qualifications are acceptable.

VII. *Nursing Service.*—1. A competent nursing service should be provided, adequate for complete coverage for both day and night periods, and for surgical and obstetric supervision. All nursing should be supervised by registered graduates. Hospitals that do general surgery should have a trained operating-room nurse.

2. Dietetics. The services of one or more graduate dietitians, as may be required, should be available for supervision of regular and special food services. Where graduates cannot be employed, these functions should be assumed by some competent person.

VIII. *Pharmacy.*—The handling of drugs should be properly supervised and should comply with all the legal regulations. Accurate records should be maintained. A qualified person should be placed in charge, preferably a graduate pharmacist; whatever arrangement is made, all prescriptions should be filled by a graduate pharmacist.

IX. *Medical Records.*—1. An adequate record system should be maintained in all departments. No certain forms are recommended since requirements vary greatly according to the size and type of hospital. Samples of suitable forms for all departments may be readily obtained from publishers of hospital records.

2. Case histories and physical examinations should be recorded immediately following the patient's admission. In no case should it be longer than twenty-four hours after admission. The history, physical examination, routine laboratory work, and provisional diagnosis should be recorded before an operation except in emergencies. The attending physician is directly responsible for the accuracy and completeness of case records, whether prepared by him or by another.

3. The usual case record consists of identification data, chief complaint, past medical history, family history, history of present illness, physical examination, provisional diagnosis; special reports such as consultations, clinical laboratory, pathology, x-ray, and the like; medical or surgical treatment, progress notes, final diagnosis, condition on discharge, and follow-up records; autopsy report when available.

4. No case record should be filed until it is complete and then only after it has been reviewed and signed by the attending physician.

5. Monthly and annual analyses of hospital service should be made in order that the staff may be in a position to improve its service.

X. *Ethics.*—In order that a hospital may be eligible for registration, it will, of course, be expected that the staff and management conform to the principles of medical ethics of the American Medical Association with regard to advertising, commissions, division of fees, secret remedies, extravagant claims, overcommercialization, and in all other respects.

For additional information, write to Council on Medical Education and Hospitals, 535 North Dearborn Street, Chicago.

"PHYSIOLOGICAL FACTORS IN ACCIDENT PREVENTION"*

It is surprising how well the public has taken to the driving of automobiles. The physical and mental examinations given are very superficial in type, and thoroughly inadequate. This must be stepped up some, but within the limits of being practical and not debarring the great masses of people from buying cars, enjoying their pleasure, or interfering with the business of automobile manufacture and sale.

Locomotive engineers practice for years as firemen before being put upon a passenger engine and then operate over private rights of way. But drivers of motor vehicles possess little or no previous training in safe use of a motor car.

No individual should receive his first license after sixty years of age. This should not be construed as limiting people over sixty years of age from driving, provided they have driven before. Just as learning to swim and ride a bicycle in childhood becomes second nature, so does driving, irrespective of age of the individual.

Health examinations should not be too strict, and a great deal of discretion must be allowed, as many an individual who is either deaf or has marked diminution of vision may, nevertheless, be a safe driver.

What must be emphasized is one's judgment of distance, color sense, and his peripheral vision.

Certain heart conditions, tendency toward apoplexy, marked high blood pressure, deformities, excessive use of intoxicating liquors, must be taken into account.

Vitamin A deficiency can be definitely determined by the biophotometer. Thus, individuals unusually sensitive to bright glare, or with insufficient vision at night, can be treated, overcoming this trouble.

Polaroid lenses will soon be used in the headlights of all cars, while the drivers will either wear polaroid glasses at the opposite axis, or have a polaroid strip which they can pull down over the windshield; thus the horizontal rays in one will be neutralized by the vertical rays in the other, and under these conditions strong headlights, 100 candle power or more, can be used with safety.

Highway patrolmen should not only have headlight and brake inspection, but should examine drivers relative to their remembrance of the road regulations and traffic signals.

Highway patrolmen are the finest body of officers in the country. Can be likened to the Canadian Mounted and the Texas Rangers. They are far too few in number. The state should have a minimum of 2,500 to take care of vacations, sickness, and extra night work, in order effectively to patrol the highways and furnish the maximum traffic safety control.

CALIFORNIA PHYSICIANS' SERVICE†

DR. RAY LYMAN WILBUR, *President*

A service organization of the physicians of California, offers complete medical and surgical care; and Associated Hospital Service of Southern California, Insurance Association of Approved Hospitals, and Intercoast Hospitalization Insurance Association offer hospitalization. All for a small monthly fee.

A small monthly payment will keep your doctors' and hospitals' bills within your budget.

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* Highlights of address delivered at California Safety Council Conference on July 25, 1939, at the Biltmore Hotel, Los Angeles, by Walter Scott Franklin, M. D., Vice-President of the California Safety Council.

From the California Safety Council, 427 West Fifth Street, Los Angeles, and 1 Drumm Street, San Francisco.

† Text here given is a reprint of an eight-page folder received from California Physicians' Service on August 9, 1939.

For other information concerning California Physicians' Service, see on pages 184-186.

Nonprofit Medical Service for California

The doctors of California have organized California Physicians' Service to give to people of small income the best of medical care, which these people could not otherwise afford.

Good medical care means complete medical care—whatever is needed by the patient, without limit of amount or kind.

California Physicians' Service is, therefore, not an insurance company, but a service organization. No limits are set on the number of doctor's visits, on specialists' or surgeons' services, on the amount of x-ray diagnosis (or x-ray or radium treatment) or the amount or cost of laboratory tests that may be needed. Within the time periods shown in this folder, Service is limited only by the needs of the patient for each illness or injury requiring treatment.

* * *

California Physicians' Service, Associated Hospital Service of Southern California, Insurance Association of Approved Hospitals, and Intercoast Hospitalization Insurance Association are all nonprofit service institutions.

There are no stockholders and no dividends. Officers and directors serve without pay. Every possible dollar buys medical and hospital services. Medical services are guaranteed by five thousand physicians of California.

* * *

California Physicians' Service

220 Montgomery Street, San Francisco
448 South Hill Street, Los Angeles

Administrative Members—A. E. Anderson, M. D.; E. Manchester Boddy, Rev. Ernest Caldecott, Charles A. Dukes, M. D.; Calvert L. Emmons, M. D.; Carl R. Erickson, John Anson Ford, Philip K. Gilman, M. D.; John W. Green, M. D.; Oliver D. Hamlin, M. D.; Junius B. Harris, M. D.; Carl R. Howson, M. D.; William H. Kiger, M. D.; Dr. Tully C Knoles, Daniel Koshland, George H. Kress, M. D.; S. J. McClendon, M. D.; Howard Morrow, M. D.; Louis A. Packard, M. D.; Alfred L. Phillips, M. D.; Dewey R. Powell, M. D.; George G. Reinle, M. D.; William W. Roblee, M. D.; Henry S. Rogers, M. D.; John C. Ruddock, M. D.; Frederick N. Scatena, M. D.; Karl L. Schaupp, M. D.; Ernest Sloman, D. D. S.; Harry H. Wilson, M. D.

Board of Trustees—Dr. Ray Lyman Wilbur, President; C. Kelly Canelo, M. D., Vice-President; Lowell S. Goin, M. D., Vice-President; Alson R. Kilgore, M. D., Secretary-Treasurer; T. Henshaw Kelly, M. D., Assistant Secretary-Treasurer; Samuel Ayres, Jr., M. D.; W. Earl Mitchell, M. D.; Glenn Myers, M. D.; Rt. Rev. Thomas J. O'Dwyer.

* * *

Associated Hospital Service of Southern California

1151 South Broadway, Los Angeles

Officers and Directors—R. E. Heerman, President; W. H. Kiger, M. D., Vice-President; Edward M. Pallette, M. D., Treasurer; Howard Burrell, Secretary; Zack J. Farmer, Alice G. Henninger, Vierling Kersey, Rev. Thomas C. Marshall, Roland Maxwell, W. S. Mortensen, M. D.; Glenn E. Myers, M. D.; Rt. Rev. T. J. O'Dwyer, Neil Petree, Hon. Lester Wm. Roth, Anna K. Volger, Robert A. Walker, M. D.; Harry H. Wilson, M. D.

* * *

Insurance Association of Approved Hospitals

369 Pine Street, San Francisco
675 East Santa Clara, San Jose
Easton Building, Oakland

Officers and Directors—W. E. Mitchell, M. D., President; Karl L. Schaupp, M. D., First Vice-President; George U. Wood, Second Vice-President; Ellard L. Slack, Treasurer; Theodore C. Lawson, M. D., Secretary; Harold Huovinen, Florence Klaeser, H. Gordon MacLean, M. D.; Arthur G. Saxe.

* * *

Intercoast Hospitalization Insurance Association

1127 J Street, Sacramento

Board of Trustees—J. D. Stephens, Chairman; R. D. Brisbane, Secretary-Treasurer; A. A. Chrisler, Ben D. Frantz, Legal Adviser; C. F. Gray, D. D. S.; J. W. O'Brien, M. D.; F. N. Scatena, M. D.

Medical Services

Medical, surgical and specialist services for diagnosis and treatment, regardless of the amount needed, up to one year for each disease or injury, as long as you are within the State of California.

These include:

- Treatment at your doctor's office
- Treatment at home if you are unable to go to your doctor's office
- Treatment at hospital if you have to be hospitalized
- Laboratory examinations, including
  - Urinalysis
  - Blood-count
  - Blood chemistry, and
  - Other required laboratory services
- X-ray diagnosis
- X-ray and radium treatment
- Services of physician-anesthetist

California Physicians' Service is not an insurance company. It is a service organization. The amount of doctors' services is limited only by the requirements of your case for modern diagnosis and care.

Choice of Doctor.—Unrestricted choice among the great majority of the doctors practicing throughout California. (Every county in California where doctors are practicing is represented in the five thousand professional members of California Physicians' Service.)

* * *

Hospital Services

Hospital care up to twenty-one days for each particular illness or injury during a contract year. Thus, it may include several different stays per year.

This includes:

- Care in room of three or more beds (private room at small additional cost)
- Meals and services of dietitian
- General nursing care
- Use of operating rooms, including surgical and anesthetic supplies
- Use of cystoscopic rooms and supplies
- Splints, casts, dressings, and drugs ordinarily furnished when hospitalized

Choice of hospitals is unrestricted among hospitals listed by the three nonprofit associations. These include more than 80 per cent of the accredited hospitals throughout California.

Hospital service described above will be furnished anywhere in California when necessary while you are under the care of any doctor who is a professional member of California Physicians' Service.

When you are away from California and overtaken by sickness or injury, you may receive hospital care in the nearest accredited hospital anywhere in the world.

* * *

Cost of Medical and Hospital Services

$1.00 registration fee.

$2.50 per month per person for full coverage.

$2.00 per month per person if you agree to pay for the first two doctor's visits in any one sickness or injury.

Note: Either medical services or hospital care may be obtained separately if both services are not desired.

* * *

Who May Join?

Employee groups or other groups (farm, business, professional, labor, not organized specifically for purpose of securing medical care) of five individuals or more not over age sixty-five. Members in such groups whose net incomes

are $3,000 or less will be furnished all the medical service their cases require without any cost whatever except monthly charges shown above.

* * *

SPECIAL NOTE

California Physicians' Service is not yet prepared to offer beneficiary membership agreements for doctors' services to families of members or to individuals not in groups. These coverages will be offered later.

Members of families of group members may secure hospital coverage *now* from the hospital associations shown below.

* * *

INSURANCE ASSOCIATION OF APPROVED HOSPITALS
INTERCOAST HOSPITALIZATION INSURANCE ASSOCIATION

Rates for Dependents of Group Members	*Per Month*
Spouse (wife or husband)	80c
Dependent child (30 days to 19 years)	40c
Dependent child (19 years or over)	90c

Where the 40-cent rate applies, all dependent children in that age group must apply or no minor child will be accepted.

Dependents will receive hospital services described, plus payment for x-ray examinations and laboratory services, *i. e.*, urinalysis, complete blood count, coagulation time, and smears, when a regular bed patient.

No additional registration fee for dependents.

* * *

BROAD COVERAGE

The conditions excluded are listed in bold-faced type in membership agreements: (See "Note" below.)

These are:

Mental disorders, drug addiction, and alcoholism.

Injuries received as result of lawless acts by the member, or intentionally self-inflicted.

Injuries covered by workmen's compensation laws.

Conditions already existing at time of becoming a member.

Services will be furnished for:

Diseases peculiar to sex.

Cancer, including deep x-ray and radium therapy.

Accidents not covered by workmen's compensation, etc.

NOTE

Hernia, Tonsil, Adenoid, Nasal Septum Operations.—Hospital and medical care both provided after you have been a member for twelve months.

Obstetrics.—Hospital care excluded. Medical service furnished after you have been a member twenty-four months.

Tuberculosis.—Hospital care excluded after diagnosis is established. Medical care furnished for one year.

Service Outside of California.—Hospitalization is furnished anywhere in the world. Medical service limited to California.

* * *

Further information concerning the services described may be secured at the offices listed below:

California Physicians' Service, 220 Montgomery Street, San Francisco; 448 South Hill Street, Los Angeles.

Associated Hospital Service of Southern California, 1151 South Broadway, Los Angeles.

Insurance Association of Approved Hospitals, 369 Pine Street, San Francisco; 675 East Santa Clara, San Jose; Easton Building, Oakland.

Intercoast Hospitalization Insurance Association, 1127 J Street, Sacramento.

PREMARITAL LAW*

Premarital Examinations for Syphilis
Suggestions for Physicians

A law requiring examinations and blood tests for syphilis before marriage goes into effect in California on September 19, 1939. It is known as Chapter 383, Acts of 1939; Article IIA, Chapter I, Title I, Part III, Division First, of the Civil Code.

Provisions of the Law

The law provides that every man and woman contemplating marriage in the State must present to the county clerk a certificate signed by a duly licensed physician stating that, at the time of examination, the applicant did not have syphilis in a form which might be communicated to the marital partner. The certificate will also carry the signature of a laboratory representative testifying that there has been made a standard serological test for syphilis as defined by the State Board of Health.

The serological test and such examination as is necessary for the discovery of syphilis must be made within thirty days before the day the license is issued. The usual confidential relationship between physician and patient shall be maintained. All laboratory reports are confidential. Violation of the confidential provisions of the law regarding certificate forms, laboratory reports and the information they contain, constitutes a misdemeanor.

When extenuating circumstances exist, the law provides that a superior court judge may order the county clerk to issue a license without the presentation of a physician's certificate.

Administration of the Law

The State Department of Public Health will distribute the certificate form to laboratories. They will not be issued direct to physicians. The laboratory will forward the certificate form to the physician at the time it sends him the report of a premarital serological test.

The only new procedures for the physician are:

1. *To designate that this is a premarital test when the specimen of blood is sent to the laboratory.*

2. *To report to the laboratory the full name and complete address of the person from whom the blood was taken.*

3. *To fill out the second half of the certificate form and give it to the person who was examined. The certificate form will be sent the physician with the laboratory report.*

Specimens may be sent by the physician to the laboratory which regularly serves him, provided it is licensed or approved to do such tests. The laboratory makes its report to the physician on the original copy of a special form provided by the State Department of Public Health. The duplicate is sent to the state health department. The triplicate is retained on file by the laboratory.

Criteria for Certification

What type of examination is necessary?

The examination should include an adequate history, an adequate physical examination and a serological test.

Who may be certified for marriage without question?

Patients who have no local lesions, no history indicative of syphilitic infection and a negative serological test. In this classification will fall 97 to 98 per cent of all persons requesting premarital examinations.

What should be done when the serological test is doubtful?

Repeat the test. Study the case until a definite decision can be made. Do not alarm the patient, but advise that the question is of such importance that guesswork is not permissible. In doubtful tests made by a local laboratory, the state laboratory is required to accept specimens for checking purposes. If there are no early lesions, if there is no

* From the California State Department of Public Health.

history suggestive of syphilitic infection, and if subsequent tests are negative or doubtful the marriage certificate should be signed.

What should be done when the serological test is positive?

Repeat the test. One positive test should not be considered sufficient to establish a diagnosis in the absence of clinical evidence of syphilis. (See *Diagnosis of Syphilis by the General Practitioner*, Supplement No. 5, to *Venereal Disease Information*. Copies obtainable from the California State Department of Public Health.)

Which factors should be considered in certifying a syphilitic person for marriage?

The danger of the patient infecting the marital partner is the only factor you are required by law to consider.

When should a syphilitic patient be allowed to marry?

Two matters should be considered in deciding the probability of a patient transmitting syphilis to the marital partner. They are duration of infection and thoroughness of treatment. The Wassermann reaction is not an index of infectiousness.

Infectiousness decreases with time. A person who has had syphilis for five years, treated or not, and regardless of whether the serological test is positive or negative, is considered, for practical purposes, noninfectious to the marital partner by most authorities and may be permitted to marry. However, there are rare cases in which infections are transmitted after five years. Persons with syphilis of long standing who have been inadequately treated should be advised that there is a possibility they may transmit the disease and urged to take a minimum of six months' continuous treatment before marriage. For such patients, treatment should be continued after marriage until the physician considers that an adequate course has been given.

Any patient with infection of less than five years' duration should be required to fulfill the following criteria: twelve to eighteen months of continuous treatment with alternating courses of an approved arsenical and heavy metal during the last year of which the patient has been seronegative. This course of treatment should be followed by a minimum of one year of probation in which the patient remains free of clinical and serological evidence of syphilis.

Any patient whose infection is of unknown duration should fulfill the same requirements as a case under five years' duration except that the Wassermann reversal is less essential.

Physicians should recognize that even the fulfillment of these requirements is not absolute proof against transmission of infection. They constitute a reasonable safeguard. A rare case may transmit infection and patients should be so advised. If they agree to take this remaining remote risk, the certificate should be issued.

If the early infection and treatment are complicated by such features as asymptomatic neurosyphilis, arsphenamin resistance, or Wassermann-fastness, marriage should be deferred until the patient has completed treatment and five years is known to have elapsed from date of infection.

The criteria recommended for issuing a certificate to a syphilitic, therefore, are as follows:

1. *A person who has had syphilis for more than five years and has not received adequate treatment may be permitted to marry, but in such cases a minimum of six months' continuous treatment before marriage is advised.*

2. *A person who has had syphilis less than five years should be given a minimum of twelve to eighteen months of continuous treatment, during the last year of which the patient is seronegative, to be followed by a year of probation during which the patient remains free of clinical and serological evidence of syphilis.*

3. *A person who has had syphilis of unknown duration should fulfill the same requirements as those outlined in paragraph 2 except that Wassermann reversal is less essential.*

Other Factors the Physician Should Consider

The danger of transmitting syphilis to the marital partner is the only matter the physician is required by law to consider in certifying a person for marriage. Good medical practice, however, requires that two other factors should also be considered: (1) the danger of transmission of syphilis to the unborn child; (2) the danger that syphilis may incapacitate the patient and shorten life, thereby adding to the economic hazards of marriage.

What is the danger of transmission of infection to the unborn child?

There is no danger that the fetus will be infected by the father if the mother does not become infected. If the mother is infected and untreated, there are approximately seven chances in eight for infection of the fetus. If the mother is adequately treated during pregnancy, beginning before the fifth month, there are at least ten chances in eleven that the child will be nonsyphilitic. Nearly absolute safety for the child may be obtained: (1) if the mother is adequately treated before pregnancy; (2) if, regardless of her own status at the time of pregnancy, she is treated continuously throughout the duration of each pregnancy.

How much weight should be given to the danger of incapacity or death from syphilis?

"The danger of incapacity or death from syphilis is a real one. . . . It is manifestly unfair for the syphilitic patient to expect his fiancée to accept this risk blindfold. If the patient's life is shortened or if, after marriage and the birth of several children, he becomes a bedridden invalid from cardiovascular or neurosyphilis, an economic tragedy may be precipitated. Marriage is a partnership, the hazards as well as the pleasures of which should be faced by both partners equally. For this reason, if for no other, no person who has acquired syphilis should contemplate marriage without a frank disclosure to his fiancée of the fact that he has had syphilis; and this announcement should be supplemented by a conference between his fiancée and physician, in which the possibilities of the future are frankly set forth. Many factors require consideration, *i. e.*, the earning capacity of the husband, his protection of life insurance, the ability of the wife to earn her own living if necessary, the possibility of financial security and insecurity. If the danger of infection is eliminated, and if the fiancée chooses to take the economic risk after full explanation, the physician need not object, even though his patient has tabes, paresis, or aneurysm."*

As far as the California law is concerned, the strictly legal obligation of the physician is clear. He need only concern himself with the question of whether the applicant for a license has syphilis which is, or may become, communicable to the marital partner. Consideration of the health and economic outlook for the patient are not legal reasons for refusing to sign a certificate.

PRENATAL LAW†

Prenatal Tests for Syphilis
Suggestions to Physicians

Prenatal serological tests for syphilis are required on and after September 19, 1939, by Chapter 127, Acts of 1939. The law requires that every licensed physician and surgeon or any other person engaged in prenatal care of a pregnant woman, or attending such a woman at the time of delivery, shall take or shall have taken a blood specimen at the time of the first visit or within ten days thereafter.

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* From Moore's *Modern Treatment of Syphilis*. Courtesy of Charles C. Thomas, Publisher, Springfield, Illinois.

† From the California State Department of Public Health.

The blood specimen thus obtained shall be submitted to an approved laboratory for a standard serological test for syphilis. The law provides:

"Any licensed physician and surgeon, or other person engaged in attendance upon a pregnant woman or a recently delivered woman, or any representative of a laboratory who violates the provisions of this Act shall be guilty of a misdemeanor; provided, however, every licensed physician and surgeon or other person engaged in attendance upon a pregnant or recently delivered woman, who requests such specimen in accordance with the provisions of Section 1, and whose request is refused, shall not be guilty of a misdemeanor."

Change in Birth Certificate

A question was added to the birth certificate by a law known as Chapter 385, Acts of 1939; Section 10200 of the Health and Safety Code. The new question follows:

"(29) Prenatal examination for syphilis, including period of gestation in months or weeks at which examination was made, and if examination was not made, including reason for not making such examination; provided, however, that the result of said examination be not included on said certificate nor made public in any manner."

Administration of the Law

The only departures from the usual routine of the physician are:

1. *In submitting the specimen to the laboratory, he must designate that this is a prenatal test.*

2. *He must report the full name and complete address of the patient to the laboratory.*

3. *He must record on the birth certificate the fact that a serological test was made.*

The laboratory makes its report to the physician on the original copy of a special form provided by the California State Department of Public Health. The duplicate is sent to the state health department. The triplicate is retained on file by the laboratory.

Since birth certificate forms are now in the process of being changed, upon recommendation of the United States Bureau of the Census, it will be some months before the new forms with this question added can be supplied.

Syphilis in Pregnancy

What shall be done if the test is negative but there is a history of syphilis?

If the patient has ever had a diagnosis of syphilis, with or without previous treatment, she should be treated throughout each pregnancy although the serology is negative. Rare exceptions to this rule are recognized.

What shall be done when the report on the test is doubtful?

Repeat the test. Study the case until a definite decision can be made. Do not alarm the patient, but advise her that the question is of such importance that guesswork is not permissible. In doubtful tests made by a local laboratory, the state laboratory is required to accept specimens for checking purposes.

What is the procedure if the test is positive?

If the test is positive and confirmed by a second examination, or if there is a history of previous infection, start treatment at once. The aim of antisyphilitic therapy in pregnancy is to prevent or cure syphilis in the child. The disease in the mother should be disregarded temporarily. There is time enough to treat her later, but there are only a few months for treatment of the infant in utero. Special treatment of the mother for neurosyphilis and other complications can wait until the end of the pregnancy.

How much treatment should be given?

Treatment should be planned according to the period of time remaining in pregnancy. Always end treatment of pregnancy with neoarsphenamin or mapharsen. For young adult women otherwise in good physical condition, treatment may be begun with neoarsphenamin or mapharsen. In patients with long-standing syphilitic infection, it is best to give two to four preliminary injections of bismuth salicylate 0.2 gram each.

The following is an acceptable treatment plan for a young adult mother two months pregnant:

Week	*Drug*
First	0.45 gram neoarsphenamin or 0.04 gram mapharsen
2nd to 6th, inclusive	0.6 gram neoarsphenamin or 0.06 gram mapharsen
7th to 12th, inclusive	0.2 gram bismuth salicylate
13th to 18th, inclusive	0.6 gram neoarsphenamin or 0.06 gram mapharsen
19th to 22nd, inclusive	0.2 gram bismuth salicylate
23rd to 28th, inclusive	0.6 gram neoarsphenamin or 0.06 gram mapharsen

This plan of treatment must be modified to meet conditions of individual pregnancy.

If treatment is started as late as the seventh month of pregnancy, neoarsphenamin and bismuth should be given each week to the end of pregnancy. If treatment is started as late as the ninth month, bismuth plus an arsenical should be given at intervals of four or five days.

Tryparsamid, because of its low spirochaeticidal activity, cannot be substituted for the trivalent arsenicals.

Congenital Syphilis

How shall a diagnosis be established in the infant?

There are two chief factors to be considered: the serological test, and the clinical manifestations.

The serological test in the infant may be positive at birth, due either to syphilitic infection or a transfer of reagin from the mother. A positive cord Wassermann, therefore, is not a reliable criterion of infection. In the absence of clinical evidence of infection, it is necessary to follow the serology of the infant for at least three months before a diagnosis can safely be made.

The recommended procedure is to test at one month and then at intervals of two weeks. If the test is still positive after three months, begin treatment even in the absence of clinical manifestations. If the test is negative, repeat the test from two to four times during the first two years.

Since the infant may develop clinical signs of syphilis during the observation period, weekly examination is necessary. If clinical evidence of syphilis appears, begin treatment immediately. This treatment consists of intramuscular injections with bismarsen or another recognized antisyphilitic drug.

What treatment should be given an infant?

The following schedule of treatment for congenital syphilis has been found highly effective. The same schedule may be used in the treatment of acquired syphilis of childhood.

UNDER ONE YEAR OF AGE

1 injection 0.05 gram bismarsen
39 injections 0.1 gram bismarsen
Injections given intramuscularly in the buttocks one time per week or two times per week.
One month vacation.
Take Wassermann.
Give one course (forty injections) after first negative Wassermann.
If Wassermann-fast, six such courses is maximum given.

OVER ONE YEAR OF AGE

1 injection 0.1 gram bismarsen
39 injections 0.2 gram bismarsen
Wassermann tests and courses as above.

If patient is sensitive to bismarsen, give forty injections of 0.1 gram of potassium bismuth tartrate.
About every sixth injection try bismarsen, 0.05 gram.

OLDER CHILDREN AND ADOLESCENTS

Adult treatment preferable or
1 injection 0.1 gram bismarsen
4 injections 0.2 gram bismarsen
35 injections 0.3 gram bismarsen
Wassermann tests and courses as above.

PROPOSED CHIROPRACTIC INITIATIVE LAW*

Explanatory Note.—This proposed Chiropractic Initiative law is an initiative which aims to amend the existing Chiropractic Practice Act, enacted in 1922.

The complete text of the initiative to be voted upon this fall (on November 7, 1939) is appended, special attention being called to the portions that are emphasized with blackface type.

* * *

(COPY)

Initiative Measure to Be Submitted Directly to the Electors

The Attorney-General has prepared a title and summary of the chief purposes and points of said proposed measure, as follows:

Chiropractors. Initiative. Amends title and certain sections of Chiropractic Act; provides secretary of Chiropractic Board shall devote full time to duties and increases his salary; increases powers of board; increases educational requirements of applicant for license; permits licensees to diagnose and treat diseases, injuries, deformities or other physical or mental conditions of human beings, without using drugs or severing any tissues of human body; specifies grounds of and proceedings for suspension or revocation of license; specifies annual renewal license fee and method of reinstating forfeited license; declares licensees shall report communicable diseases and sign birth and death certificates.

State of California,
County (or City and County) of,—ss.

To the Honorable, the Secretary of State of the State of California:

We, the undersigned, registered, qualified electors of the State of California, residents of the county (or city and county) of ———, hereby present to the Secretary of State this petition and hereby propose a law and act entitled as follows: "An act to amend the title and Sections 3, 4, 5, 7, 10, 12 and 13 of that certain act entitled 'An act prescribing the terms upon which licenses may be issued to practitioners of chiropractic, creating the state board of chiropractic examiners and declaring its powers and duties, prescribing penalties for violation hereof, and repealing all acts and parts of acts inconsistent herewith,' " approved by the electors at the general election on November 7, 1922; providing for the organization of the state board of chiropractic examiners, and providing for its officers, duties, powers and compensation; regulating the practice and licensing of chiropractors; defining the scope of practice of licensees; establishing educational requirements and other qualifications for licensees; fixing license and renewal fees; providing for the issuance, suspension, revocation and reinstatement of licenses; providing for investigation and approval of chiropractic schools and colleges; requiring reports of communicable diseases; and repealing all conflicting provisions of other acts, to read as hereinafter set forth in full, and petition that the same be submitted to the electors of the State of California for their adoption or rejection at the next succeeding general election or as provided by law.

The proposed law and act is as follows:

An act to amend the title and sections 3, 4, 5, 7, 10, 12 and 13 of that certain act entitled "An act prescribing the terms upon which licenses may be issued to practitioners of chiropractic, creating the state board of chiropractic examiners and declaring its powers and duties, prescribing penalties for violation hereof, and repealing all acts and parts of acts inconsistent herewith," approved by the electors at the general election on November 7, 1922; providing for the organization of the state board of chiropractic examiners and providing for its officers, duties, powers and compensation; regulating the practice and licensing of chiropractors; refining the scope of practice of licensees; fixing license and renewal fees; providing for the issuance, suspension, revocation and reinstatement of licenses; providing for investigation and approval of chiropractic schools and colleges; requiring reports of communicable diseases; and repealing all conflicting provisions of other acts.

The people of the State of California do enact as follows:

Section 1. The title of that certain act entitled "An act prescribing the terms upon which licenses may be issued to practitioners of chiropractic, creating the state board of chiropractic examiners and declaring its powers and duties, prescribing penalties for violation hereof, and repealing all acts and parts of acts inconsistent herewith," approved by the electors at the general election on November 7, 1922, is hereby amended to read as follows:

"An act creating the state board of chiropractic examiners, and providing for its organization, members, duties and powers; regulating the practice and licensing of chiropractors and defining the scope of practice thereof; providing for the investigation and approval of chiropractic schools and colleges; establishing educational requirements and other qualifications for licensees; fixing license fees; providing for the issuance, suspension, revocation and reinstatement of licenses; prescribing penalties for violation hereof, and repealing all conflicting provisions of other acts."

Section 2. Section 3 of said act is hereby amended to read as follows:

Sec. 3. The board shall convene within thirty days after the appointment of its members, and shall organize by the election of a president, vice-president and secretary, all to be chosen from the members of the board. Thereafter elections of officers shall occur annually at the January meeting of the board. A majority of the board shall constitute a quorum.

It shall require the affirmative vote of three members of said board to carry any motion or resolution, to adopt any rule, or to authorize the issuance of any license provided for in this act.

The secretary shall receive a salary to be fixed by the board in an amount not less than three thousand six hundred dollars per annum and not more than four thousand two hundred dollars per annum, together with his actual and necessary traveling expenses incurred in connection with the performance of the duties of his office, and shall give bond to the state in such sum with such sureties as the board may deem proper. He shall devote his full time to the performance of his duties as such secretary. He shall keep a record of the proceedings of the board, which shall at all times during business hours be open to the public for inspection. He shall keep a true and accurate account of all funds received and of all expenditures incurred or authorized by the board, and on the first day of December of each year he shall file with the governor a report of all receipts and disbursements and of the proceedings of the board for the preceding fiscal year.

Section 3. Section 4 of said act is hereby amended to read as follows:

Sec. 4. The board shall have power:

(a) To adopt a seal, which shall be affixed to all licenses issued by the board.

(b) To adopt from time to time such rules and regulations as the board may deem proper and necessary for the enforcement of this act, copies of such rules and regulations to be filed with the secretary of the board for public inspection.

(c) To examine applicants and to issue and revoke licenses to practice chiropractic, as herein provided.

(d) To summon witnesses and to take testimony as to matters pertaining to its duties; and each member shall have power to administer oaths and take affidavits in connection with board matters.

(e) To approve every chiropractic school or college which complies with the provisions of this act and the rules and regulations of the board. Nothing in this act shall prohibit the board from withdrawing its approval of any chiropractic school or college after such approval has been granted.

(f) To promulgate and adopt rules and regulations for the conduct of chiropractic schools and colleges. Each chiropractic school or college in order to obtain the approval of the board shall make application therefor to the board in writing, and shall furnish such information regarding such school or college as may be required by the board. Said schools or colleges shall at all reasonable times permit any member of the board or any representative thereof to enter upon the premises of such school or college and to inspect the facilities and records thereof.

(g) To publish an annual directory, a copy of which shall be delivered to each licentiate without cost. Copies of said directory may be sold to other persons at one dollar per copy.

* For editorial comment, see page 147.
For digest of an opinion on the existing chiropractic law, see on page 213.

(h) To employ an assistant secretary, inspectors, attorney, and such other clerical assistance as the board may deem necessary.

(i) To do any and all things necessary or incidental to the exercise of the powers and duties herein granted or imposed.

Section 4. Section 5 of said act is hereby amended to read as follows:

Sec. 5. It shall be unlawful for any person to practice chiropractic in this state without a license so to do. An applicant for a license hereunder must be not less than twenty-one years of age, of good moral character, and must submit satisfactory proof of graduation from a high school requiring not less than fifteen units for graduation. He must apply to said board at least fifteen days prior to any meeting thereof, upon such form and in such manner as the board may provide, and the application must be accompanied by a fee of twenty-five dollars.

Except in cases herein otherwise provided for, an applicant for a license to practice chiropractic must be a graduate of a chiropractic school or college approved by said board, which teaches a course of instruction of not less than four thousand hours in the subjects hereinafter enumerated in this section, extended over a period of four school terms of not less than nine months each.

An applicant for a license hereunder must submit satisfactory proof of actual attendance during not less than ninety per cent of the hours herein prescribed.

For the purposes of this act, an academic "hour" shall be construed as a period of not less than fifty minutes. The hours of instruction and the subjects required of an applicant for a license to practice chiropractic, and the minimum of hours and courses to be taught by an approved chiropractic school or college are as follows:

Subject	*Hours*
Dissection	150
Histology	100
Anatomy	600
Bacteriology	100
Chemistry (including fifty hours laboratory)	150
Hygiene and sanitation	100
Toxicology	50
Physiology	300
Pathology	300
Physical diagnosis and analysis	450
Chiropractic theory and practice	500
Obstetrics	200
Gynecology	100
Spinography	100
Biology	100
Physics	100
Dietetics, including endocrinology, biochemistry and food chemistry	300
Physical therapy and practice	300
Total	4000

Section 5. Section 7 of said act is hereby amended to read as follows:

Sec. 7. One form of certificate shall be issued by the board of chiropractic examiners; said certificate shall be designated "License to practice chiropractic," which license shall authorize the holder thereof to diagnose and treat diseases, injuries, deformities or other physical or mental conditions of human beings, without the use of drugs and without in any manner severing any of the tissues of the human body.

Section 6. Section 10 of said act is hereby amended to read as follows:

Sec. 10. (a) Said board shall refuse to grant, or may suspend or revoke a license to practice chiropractic in this state upon any of the following grounds:

First—Procuring or aiding or attempting to procure a criminal abortion.

Second—Violating or attempting to violate, directly or indirectly, or failure to comply with, any provision of this act.

Third—Wilfully betraying a professional secret.

Fourth—Revocation or suspension by a sister state of a license by virtue of which one is licensed to practice in this state.

Fifth—Employing, directly or indirectly, any unlicensed practitioner in the practice of chiropractic, but this provision shall not be construed to prohibit the employment of nurses or other bona fide assistants by licensees under this act.

Sixth—Advertising which is intended or has a tendency to deceive the public or to be harmful to public morals or safety, or the advertising of definite or fixed prices for professional services.

Seventh—Advertising of any treatment, medicine or method whereby the monthly periods of women can be regulated or the menses reëstablished.

Eighth—Conviction of a felony or of any offense involving moral turpitude in which cases the record of such conviction shall be conclusive evidence.

Ninth—The purchase or sale, or offer to purchase or sell, the alteration of, or fraudulent use of, any chiropractic or other diploma, degree or license.

Tenth—Fraud in an application or examination for a license.

Eleventh—Practicing chiropractic under a false name or the impersonation of another chiropractor.

Twelfth—Habitual intemperance or excessive use of ardent spirits or narcotics.

Thirteenth—Advertising, directly or indirectly, in any manner, that a licensee hereunder, or any person or company connected with him, will treat or cure, or attempt to treat or cure, any venereal or sexual disease, weakness or disorder.

Fourteenth—Failure or refusal to record a license as required by this act.

Fifteenth—The employment of "cappers" or "steerers" or other persons in procuring chiropractic practice.

Sixteenth—Misrepresentation in connection with alleged rights or privileges to practice as a licensee under this or any other professional act.

(b) Before any license is suspended or revoked by said board, the licensee shall be furnished with a specification of the ground or grounds upon which suspension or revocation of his license is contemplated and after reasonable notice thereof to the licensee the board shall conduct a hearing in the matter at which time the licensee may be represented by counsel.

(c) If an application for a license is refused by said board, or if after notice and hearing a license issued is suspended or revoked, the aggrieved person may commence an action in the superior court against the board to compel the granting of the application or to cancel the act of the board in suspending or revoking the license, as the case may be, or for any other appropriate relief, such action to be in the nature of a proceeding in review. Every order of the board shall be final and conclusive as to questions of fact. A proceeding to review an order of the board must be filed within thirty days after the issuance of the order and tried in the county in which the board hearing was held or in any county wherein the board maintains an office.

(d) The secretary shall enter in his records the fact of such revocation or suspension, and shall certify that fact to the county clerk of the county in which the license has been recorded pursuant to Section 11 hereof. Said clerk must thereupon endorse that fact, opposite the name of the licensee in his said record. The record of such revocation or suspension so made by said clerk shall be prima facie evidence of the fact thereof, and of the regularity of all proceedings of said board in the matter of said revocation or suspension.

(e) After two years from the revocation of a license said board may make an order of restoration and issue a new license upon application therefor accompanied by a fee of twenty-five dollars.

Section 7. Section 12 of said act is hereby amended to read as follows:

Sec. 12. Each person licensed under this act shall, on or before the first day of January of each year, after a license is issued to him as herein provided, pay to said board of chiropractic examiners a renewal fee of not less than five dollars nor more than ten dollars, to be fixed annually by the board. The secretary of the board shall, on or before November first of each year, mail to all licensed chiropractors in this state, a notice that the renewal fee will be due on or before the first day of January next following. The failure, neglect or refusal of any person holding a license or certificate to practice under this act to pay said annual fee during the time his or her license remains in force shall, after a period of sixty days from the first day of January of each year, ipso facto, work a forfeiture of his or her license or certificate, and it shall not be restored except upon the written application therefor within a period of two years from delinquent date and the payment to said board of a delinquent penalty of ten dollars, together with all renewal fees delinquent, provided that such licentiate who reinstates said license or certificate within the period of two years shall not be required to submit to an examination for the reinstatement of such certificate.

Section 8. Section 13 of said act is hereby amended to read as follows:

Sec. 13. Chiropractic licentiates shall observe all state and municipal regulations relating to the reporting of communicable diseases, and shall sign birth and death certificates and make the required reports and file them with the proper authorities as required by law and such reports shall be accepted by the officers of the departments to which they are made.

CHIROPRACTIC: SCOPE OF CHIROPRACTIC IN CALIFORNIA *

"Chiropractic as Taught in Chiropractic Schools" Construed

The defendant was a chiropractor licensed under the provisions of the Chiropractic Initiative Act adopted in California in 1922. He was convicted of a violation of the Medical Practice Act, now forming a part of the Business and Professions Code of California, and appealed to the appellate department, superior court, Los Angeles County, California.

It was not necessary, the Court said, for the complaint to negative the possession of a chiropractic license by the defendant. The operative effect of the 1922 chiropractic initiative was the same as that of an exception or limiting proviso placed in the same act with a prohibition which is not a part of the definition of the offense. It is the rule in such matters that it is not necessary in a criminal charge to negative such an exception or proviso.

Prior to the 1922 chiropractic initiative, chiropractors in California could by virtue of a provision in the Medical Practice Act obtain from the Board of Medical Examiners licenses to practice as drugless practitioners, without the use of drugs or medical preparations and without severing or penetrating any of the tissues of human beings, except the severing of the umbilical cord. The 1922 chiropractic initiative created a Board of Chiropractic Examiners and provided that a license issued by the Board authorized the holder—

> to practice chiropractic in the State of California as taught in chiropractic schools or colleges; and, also, to use all necessary mechanical, and hygienic and sanitary measures incident to the care of the body, but shall not authorize the practice of medicine, surgery, osteopathy, dentistry, or optometry, nor the use of any drug or medicine now or hereafter included in materia medica.

The proponents of the 1922 initiative, the Court pointed out, then argued that their complaint was not against the limited form of license under which they practiced, but against the unfair administration of the Medical Practice Act as it applied to chiropractors. They assured the voters that the proposed initiative prohibited the use of "drugs, surgery, or the practice of obstetrics by chiropractors." This argument, the Court said, while not conclusive, may be considered as an aid in interpreting the initiative. The decision of the Court in this case does not indicate, except by inference, specifically the type of practice in which the defendant engaged. It does discuss exhaustively the scope of chiropractic in California.

The Court disagreed with the defendant's contention that he was authorized to practice any method of healing that is taught in chiropractic schools and colleges. The practice authorized by the initiative. the Court observed, must be "chiropractic," and it must also be "as taught in chiropractic colleges." Neither of these expressions can rule the meaning of the initiative to the exclusion of the other. The Court quoted from various sources to show that the term "chiropractic," at the time the initiative was adopted in 1922, meant a system of healing that treated disease by manipulation by hand of the spinal column. This general consensus of definitions, the Court continued, showed what was meant by the term "chiropractic" when used in the initiative act, for the words of an act must be taken in the sense in which they were understood at the time when the Act was enacted. Nor, the Court observed, has the accepted definition of the word since changed. The effect of the words "as taught in chiropractic schools or colleges" is not to set at large the signification of "chiropractic," leaving the schools and colleges to fix on it any meaning they choose. The scope of chiropractic being well known, the schools and colleges, so far as the authorization of the chiropractor's license is concerned, must stay within its boundaries. They cannot exceed or enlarge them. The trial court, in the opinion of the appellate court, correctly instructed the jury as follows:

> It is thus seen that the authority granted to a chiropractor to practice the arts taught in chiropractic schools and colleges is limited by the restriction that such practice may not invade the field of medicine or surgery, nor may the chiropractor use any drug or medicine included in materia medica, even though certain phases of the practice of medicine or surgery or the use of such drugs or medicines may have been taught in chiropractic schools or colleges. In other words, the chiropractor is limited to the practice of chiropractic and the use of mechanical hygienic and sanitary measures incident to the care of the body, which do not invade the field of medicine and surgery, irrespective of whether or not additional phases of the healing art, including medicine and surgery or the use of drugs, may have been taught in chiropractic schools or colleges.

The defendant contended that the limiting language found in the Chiropractic Initiative Act that licenses issued thereunder shall not authorize the practice of medicine, surgery, osteopathy, dentistry or optometry, nor the use of any drug or medicine now or hereafter included in materia medica, was purely surplusage and should be wholly disregarded. This was certainly not the position taken by the proponents of the 1922 initiative, the Court pointed out, nor did the people have any such intent in adopting the Act, if they paid any attention to the positive assurance given them by the proponents, as the Court supposed they did. The defendant argued that chiropractic is merely a phase of medicine and surgery, and since the license provided by the initiative act expressly permits the practice of chiropractic, the limitation was repugnant to the grant and must be ignored. But, the Court pointed out, all the parts of an act must be considered together and meaning and effect must be given, if possible, to each and every part. The initiative must, then, mean something by its provision that a chiropractic license shall not authorize the practice of medicine or surgery. Obviously, it does not mean to prohibit what has just been expressly authorized; that is, the practice of chiropractic. In view of the fact that the proponents of the initiative declared in 1922 that "the teachings and practice of chiropractic are admittedly different from those of medicine," that there was no objection to the scope of the license which a chiropractor could obtain under the Medical Practice Act, and that under the proposed initiative, chiropractors could not use drugs or surgery, the Court in the present case concluded that the words "medicine" and "surgery," as used in the initiative act, were intended to continue, as to chiropractors, the limitations imposed on drugless healers by the Medical Practice Act; that is, to deny them the use of drugs and medical preparations and the severing or penetrating of the tissues of human beings.

The defendant objected to an instruction given by the trial court that excluded chiropractors from the use of proprietary medicines. But, the Appellate Court said, that instruction was in accordance with the language of the initiative itself, which makes no exception of medicines that are "proprietary." The Act declares that persons licensed under it shall not practice medicine, a practice which certainly includes the use and prescribing of medicines in whatever form or combination they may be prepared or sold. It also prohibits the use by licensees of "any drug or medicine now or hereafter included in materia medica." The term "materia medica" is defined in Webster's New International Dictionary, 1926 edition, as follows: "(1) Material or substance used in the composition of remedies: a general term for all substances used as curative agents in medicine. (2) That branch of medical science which treats of the nature and properties of all the substances employed for the cure of diseases; one of the two branches of pharmacology." For the present purpose, the Court said, it makes little difference which of these two meanings is to be given the term as used in the chiropractic initiative. Taking it in either sense, the effect of the pro-

* Digest of an opinion handed down by the Appellate Court of California.

For editorial comment, see page 147. Copy of the proposed initiative appears on page 211.

hibition cannot be evaded by mixing one of the included drugs or medicine with something else and calling it, whether rightly or wrongly, a proprietary medicine.

The Appellate Court could find no error in the record, and the judgment of conviction was affirmed. *People* vs. *Fowler* (Calif.), 84 P. (2d) 326.—*Journal of the American Medical Association.*

UNITED STATES NATIONAL HEALTH PROGRAM: WAGNER BILL, S. 1620

Digest of the Preliminary Report from the Committee on Education and Labor of the United States Senate*

In submitting its preliminary report (Senate Report No. 1139, Seventy-Sixth Congress, First Session) the subcommittee of the Committee on Education and Labor points out that it is in agreement with the general purpose and objectives of the Wagner Bill, Senate 1620, establishing a National Health Program; it wishes, however, to give this legislation additional study and to consult further with representatives of lay organizations and of the professions concerned.

The subcommittee states that it intends to report out an amended bill at the next session of Congress.

I. Need for a National Health Program

The preliminary report states that this bill is the result of several years of preparatory study and discussion, and that it grew out of the movement which led to the Social Security Act of 1935, followed by the National Health Conference, the National Health Survey, and various other activities.

The evidence presented shows convincingly, the Committee believes, that there are great opportunities to improve health conditions in this country. It is felt that we should be able to make still further improvements on the excellent records in the field of health that prevail today. Special reference is made to the opportunity to save lives threatened by tuberculosis. It is said that the funds available for venereal diseases are sufficient to make only a beginning in this campaign.

The report emphasizes that 11,000 mothers died in childbirth in 1937 and alleges that more than one-half to two-thirds of such maternal deaths are preventable. It is said also that each year nearly a quarter of a million women do not have the advantage of a physician's care at the time of delivery. Vastly more could be done than is being done to conserve the lives and health of children.

The report indicates the belief that only those in the upper income groups receive anything approaching adequate dental care.

There is a discussion of the extra hazards associated with industry, and much is said of the need of new methods of medical service in rural areas.

Emphasis is placed on the statement that there is wide variation among the states in the availability of hospital facilities. With regard to general hospitals, the number of available beds varies among the states from a maximum of 5.2 to a minimum of 1.3 for every thousand of population. The record for the country as a whole indicates an average of 3.1 beds for every thousand persons, and the report asserts that adequate standards for general hospitalization call for an average of 4.5 beds in general hospitals for every thousand persons.

There are also great differences among the states in the availability of beds in mental institutions.

Costs of Adequate Health Services

The preliminary report calls attention to the fact that there are various factors which explain why large proportions of the population fail to receive the medical and health service they need. The Committee recognizes the fact that ignorance, reliance on unsuitable methods, great distances from physicians, and so on, play a part, but it says that, from the evidence placed before it, the major reason is lack of financial ability on the part of large portions of the population to meet the costs of needed services. It has accepted the idea that many who could buy medical care on some budget basis find it difficult to purchase service on the customary basis of paying for the care when the need for the care arises.

Figures are cited from the National Health Survey to show that the average number of physician's calls per case is higher among the well-to-do than among the poor. The committee repeats the statement of a witness for the American Medical Association to the effect that among the one-fourth of the states with the highest percentage of population filing income tax returns there was an average of one general hospital bed for 261 persons in the population and that these beds were being used 65.5 per cent of their capacity. In the one-fourth of the states at the other end of the economic scale, there are 549 persons per general hospital bed with an average occupancy rate of only 52 per cent.

Much emphasis is placed on the report supplied by Dr. R. G. Leland, Director of the Bureau of Medical Economics, who testified on behalf of the American Medical Association and who supplied factual data on medical economics.

The Committee said: "We cannot emphasize too strongly or say too often that when we speak of inadequate medical care, of insufficient services received by large numbers of people, or of the economic problems in paying for care, we are not criticizing the physicians or hospitals or others who furnish services. They have long been performing humanitarian services deserving the highest praise. It is not the responsibility of doctors or hospitals or related groups that large sectors of the population have limited economic resources."

The Committee paid tribute also to the work of the voluntary organizations and stated that "every right-thinking citizen will insist that in the health program for the future there shall be adequate provision for the continued vigorous activity of the voluntary organizations."

Disability Insurance

The Committee believes that the program of social security which this country has established is incomplete without protection of the individual against the risk of losing his earning power because of disability. The Committee feels that, if adequate protection against the risk of disability is to be developed, insurance must be made obligatory, as has already been done in the case of protection against unemployment in old age.

The Need for Federal Action

The Committee argues that it does not propose a new departure or a new type of activity for the Federal Government. "It is our opinion," it says, "that the administration and operation of health services should be left to the local communities and to the states, and that the Federal Government should not control or dictate to the local communities or states in the management of these functions. . . . The primary opportunity for the Federal Government is to give financial and technical aid to the states."

It is pointed out that the Federal Government is now providing aid to the states for a variety of purposes having to do with the general welfare and with health. The Committee points out that the public hearings have shown that there is a broad and substantial support now for federal legislation to strengthen, extend and improve the health

* Digest compiled from Report No. 1139 (forty-two pages), submitted under date of August 4, 1939, to the Seventy-Sixth Congress, by Senator Murray for the Senate Committee on Education and Labor. Digest is reprinted from *The Journal of the American Medical Association,* August 19, 1939, page 685.

For editorial comment, see in this issue, on page 148.

services of our people. Scarcely a witness raised objection to the objectives of the bill, although representatives of some organizations presented serious criticisms.

II. Principles Underlying the Bill

Here the Committee presents an analysis of the bill, together with statements by Abel Wolman, Dr. Felix J. Underwood, Dr. A. T. McCormack, Dr. Thomas Parran, and Miss Katharine Lenroot, in support of the form of S. 1620.

III. Principal Provisions of the Bill

There follows an analysis of the bill as it now stands and a table of comparison of present appropriations for health purposes under the Social Security Act and the appropriations proposed to be authorized by S. 1620.

IV. Some Special Problems Raised in the Hearings

It is pointed out that some witnesses objected to the grant-in-aid pattern embodied in the bill. The Committee felt that the bill would appear to follow a fundamentally sound principle when it leaves to the states the decision as to the population groups to be served by their plans. The Committee has under consideration the question of providing funds for federal support of professional education, administrative training and research. The Committee is prepared to make the intention of the bill to provide for health education of the public clear and specific.

There is much discussion of the recommendation that one federal agency should administer medical affairs. It is pointed out that further study is required on the matter of the relationship between the Federal Security Administration and the Children's Bureau of the Department of Labor and between them and other federal agencies. There is also the question of having a single federal advisory council or a national health council instead of several federal advisory agencies.

The Committee considered particularly the question of the protection of minority population groups and asserts that the Committee believes that there should be just and equitable allocation of funds according to the needs for services.

On the question of the eligibility of practitioners from various schools of healing, the Committee states that it is impressed by the fact that the licensing and regulation of practitioners in medicine and allied fields have always been within the jurisdiction of the states and not under the Federal Government, and the Committee feels that the powers should be left in these states as at present and that, therefore, the bill should not include any specifications on these points except a provision to the effect that nothing in the bill should be construed as infringing on the authority of each state to continue to regulate the practice of the healing arts.

On the question of the construction of hospitals, the Committee states that this title is not intended to lead to any unsound activity. Before any new hospital construction is undertaken, the available beds in qualified, existing, nongovernmental and governmental hospitals should be used, provided the type of service meets accepted standards and the charges for the use of such beds are reasonable. The Committee says, "We have no intention whatever of endorsing any proposal that would encourage the building of hospitals where adequate facilities exist or that would encourage the building of public hospitals where private hospital construction would, in the normal course of events, meet community needs." It says: "Furthermore, our Committee intends to prepare amendments to Title 12 to assure that federal aid under this title will require unequivocally clear showing of need through impartial state and local surveys, and clear satisfaction of federal requirements that such needs exist, in addition to reasonable demonstration as to future continuing support of the hospitals." The report says that "the Committee is agreed that the bill should be amended by addition of positive provisions that qualified hospitals and agencies, both public and private, may be utilized in the state plans."

V. Conclusion

"S. 1620 has received wide support from large and representative organizations. Its objectives are noncontroversial. Our Government is dedicated to promoting the welfare of the people and the protection and improvement of health and well-being. Making available to all of the people the great life-saving services which modern medicine has to offer is an objective which every right-thinking citizen supports.

"The Committee is convinced that federal legislation along the general lines followed by S. 1620, based upon federal-state coöperative programs, is necessary to strengthen the health services of the nation and to make provision for the progressive and effective improvement of health conditions in all parts of the country and among all groups of people. The needs are large, and an adequate program to put knowledge and skill more effectively to work will involve considerable expenditures of funds. The program must, therefore, be worked out with great care. We are confident that such a program can be worked out and that the expenditures will be sound national investments which will bring large returns. The rôle of the Federal Government should be primarily to give technical and financial aid to the states.

"A critical analysis of the present provisions of S. 1620 shows a number of points at which its specific purposes can be more clearly stated and its provisions improved. The Committee has not yet reached any conclusions concerning the precise rate at which federal appropriations should be increased, but the Committee is agreed on the general principle that the proportion of federal assistance should be greater to those states in which there is the greatest need for the services contemplated under the bill. The Committee is prepared to augment the provisions of the bill—if additional provisions are needed—to assure that the amount of federal assistance would in no instance be in excess of clearly demonstrated need.

"Some misunderstandings seem to have arisen and criticisms have been expressed concerning parts of the bill. Some witnesses have assumed that it would bring about revolutionary or dangerous changes in medical care. We think these fears are unwarranted, but we will welcome further suggestions as to specific amendments which may safeguard the objectives of the bill. Medical science has reached a commendable status in this country. The bill should encourage the further evolutionary development of medical science, teaching and practice.

"The Committee has received the assurances of many lay and professional groups that they will be prepared to furnish further information and suggestions. We expect to consult further with representatives of these groups.

"We have not yet had adequate time to make exhaustive study of all of the problems involved in the legislation proposed by S. 1620. The Committee will continue its study of S. 1620 so that a definitive report on the proposed legislation can be submitted soon after the beginning of the next session of the Congress."

By study man produced the stone tool, the bow and arrow, the numerals, and the alphabet. Likewise tillage, books, and all else by which he lifted himself out of savagery. Among his great works—poems, commerce, and government—each is a creation of the mind. The structures in which man resides, works, and escapes the pelting elements, the conveyances in which he travels, are but mental reflections that have taken tangible form.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XII, No. 9, September, 1914

From Some Editorial Notes:

The Osteopathic Situation.—The Journal has already printed an official statement of the fact that the many "drugless healers" were energetic in their efforts to secure an initiative on the ballot at the next election, their proposed law being one which practically does away with all control of medical standards in the matter of license to practice, and would also allow osteopathic and other similar schools to grant the degree of doctor of medicine, etc. The "Los Angeles County Osteopathic Association" is at the top of a circular letter dated July 16, 1914, which letter was apparently sent to a number of people with a request that they get signatures to the enclosed petition to the Governor, asking him to do many things. . . .

* * *

Our Delegates at the Atlantic City Meeting.—A member of our society who was present at all the meetings of the delegates of the American Medical Association has sent in the following statement of his views and observations:

"It has occurred to me that a brief account of the splendid work of the California delegates at the recent meeting of the American Medical Association at Atlantic City would prove acceptable to your readers. As an interested spectator throughout the Thursday afternoon session of the House of Delegates, at which the election of officers and selection of the next place of meeting took place, I had the privilege of seeing our representatives play the game and win out on every count.

"Drs. V. G. Vecki, H. Bert Ellis, and George Hare, the California delegates, sat together, taking no active part in the proceedings until the interests of their own state became an issue. When nominations to fill the vacancy in the Board of Trustees made by the expiration of the term of office of Dr. Philip Mills Jones were called for, he was promptly named to succeed himself, only one other nomination being made. The first ballot resulted in a tie. Then our boys got very busy, and the second ballot landed our Secretary-Editor in his old berth by a safe margin. This happy result should be—and undoubtedly is—most gratifying to our society and to the profession of the state at large.

"The matter of the next place of meeting came up on the report of the Standing Committee on Transportation and Place of Meeting. This report unanimously recommended Chicago for the 1915 meeting, thus placing a heavy handicap on San Francisco. Doctor Vecki immediately moved that the report be amended by substituting San Francisco for Chicago, and proceeded to speak in eloquent terms of the former's claims. A merry war now developed. . . . The effect was instantaneous. The question was at once put to vote, and San Francisco was 'it' by a large majority. . . ."

* * *

The State University Establishes a Graduate School at Los Angeles.—Announcement has been made by the Regents of the University of California, that, commencing on July 1, 1914, the Los Angeles Medical Department of the University of California would discontinue undergraduate instruction to third and fourth year medical students, and would hereafter confine its work to instruction of graduates of medicine. By taking this step, the Regents

(Continued in Front Advertising Section, Page 24)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.
Secretary-Treasurer

Board Proceedings

A special examination was held in Belmont High School, Los Angeles, August 7 to 10, inclusive, 1939. Approximately thirty-seven reciprocity applicants took the oral examination and seventy-seven graduates of medical schools took the written examination.

* * *

News

"According to press reports, there will be an initiative measure on the ballot in November, in addition to the 'Ham and Eggs' proposal. Its object is to permit chiropractors to sign birth and death certificates. We question the value of this proposal. What is to be gained by chiropractors being permitted to confine womanhood in view of known lack of proper learning by the great majority of this profession in the technique of medicine? . . . Every safeguard should surround womanhood in confinement by the best practice. Chiropractic technique is not one of them." (Editorial, Isleton *Journal,* August 4, 1939.)

"Dr. David Long, youthful chiropractor who recently won for his profession the right to practice obstetrics, was to be the principal speaker today at the opening session of the national convention of the American Progressive Chiropractic Association. The six-day meeting is being held at the Los Angeles Chiropractic College. . . . Doctor Long's topic will be 'Normal Delivery of a Baby.' He recently won a test case, instituted by the State Medical Board, to determine the right of a chiropractor to practice obstetrics. . . ." (Los Angeles *Evening News,* July 31, 1939.)

"The American Progressive Chiropractic Association yesterday announced that it would take definite steps to secure a chiropractic unit in General Hospital for patients requesting chiropractic treatment. A decision to 'go the limit' was reached by members of the Association, now holding their sixteenth annual national convention at Los Angeles College of Chiropractic, when it was reported County Supervisor Gordon L. McDonough had refused to grant the long-sought petition for a ward in General Hospital, to be maintained by the chiropractors at no expense to taxpayers. Two courses of action are planned to force the issue. One will be through a taxpayers' petition demanding hospital space or filing of a writ of mandamus suit to compel the Board of Supervisors to heed the demands of the chiropractors." (Los Angeles *Daily News,* August 5, 1939.)

"Governor Olson issued a special statement in pocket-vetoing A. B. 449, by Assemblyman Chester F. Gannon of Sacramento County, which would have required United States citizenship to obtain a license to practice medicine in California. 'This bill,' said Olson, 'would eliminate practice by some of the world's greatest medical scientists. It would also work a hardship on other qualifying physicians by compelling a wait of several years necessary to acquire citizenship before being permitted to earn a livelihood in their profession. The bill would deny such privilege to aliens even if they have declared their intention to become American citizens. The bill is not directed toward

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† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.